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MAY-JUNE, 1957

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

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RALEIGH, N. C.

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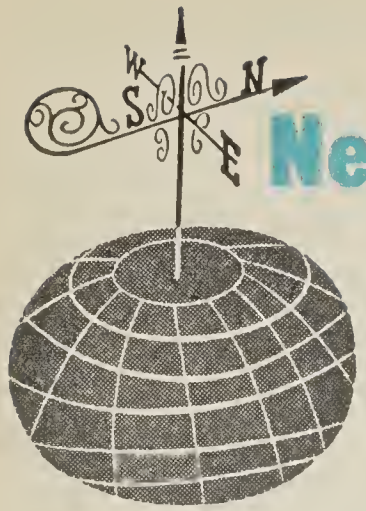

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

SCOTLAND: The first Scottish AA Convention was held at Dunblane from April 12 to April 14. It was organized by the Scottish Inter-Group and was the first AA convention on such an ambitious scale. All AA groups in Scotland were represented at the Convention.

CHICAGO: Under a new program instituted by the Chicago Police Department, habitual alcoholics can now turn to the policeman for help instead of being locked up in a jail cell for "sobering up." With the help of AA, a booklet has been prepared outlining help available to the alcoholic. The booklet was distributed to the city's 8,000 policemen and 871 Park District officers. They, in turn, distribute the literature to the alcoholics. Included in the booklet is a test questionnaire used by John Hopkins University for use in determining whether or not a person is an alcoholic. A foreward to the booklet says the instructions therein are a source of information to a person "who honestly wants to quit drinking." The police department's chief surgeon, Dr. Pat S. Vitullo, said there are more than 33,000 chronic alcoholics in Chicago and 100,000 problem drinkers and that they are increasing at the rate of 2,300 per year.

KANSAS: The Kansas Commission on Alcoholism, established in 1953 will have to suspend operations on June 30th. A statement from THE KEY, publication of the KSCA says, "We regret that the Commission can no longer maintain its activities due to the veto by Governor Docking of its appropriation."

NORTH CAROLINA: The NCARP has awarded 22 scholarships to persons wishing to attend the School of Alcohol Studies to be held at New Haven from June 30 to July 25. Recipients of the awards include ministers, nurses, physicians, social workers and those engaged in public instruction. The NCARP offers these Yale scholarships annually so that more North Carolinians may become professionally oriented in the physiology of alcohol, related alcohol problems, treatment of alcoholism and theories on the causation of alcoholism.

UTAH: The 6th annual session of the Utah School of Alcohol Studies will be conducted at Salt Lake City from June 16 until June 22. The School is sponsored jointly by the Utah State Board on Alcoholism, the Utah Alcoholism Foundation and the University of Utah. The course is offered to educators, law-enforcement officers, nurses and medical personnel, social and welfare workers, clergymen, industrial and community leaders and anyone else desiring further understanding of alcoholism.

BRITISH COLUMBIA: A documentary program on alcoholism, entitled "One Man's Poison" was broadcast over the CBC radio stations April 22 at 6:20 P.M. The program featured interviews on alcoholism and discussed the Alcoholism Foundation of British Columbia. All CBC stations in British Columbia and the CBU Vancouver station carried the broadcast.

ROME: Mrs. Marty Mann, Director of the National Council on Alcoholism, delivered two addresses on alcoholism to the Third Conference of the International Union for Health Education of the Public, held in Rome from April 28 through May 5. Over 1,000 delegates from 56 countries heard Mrs. Mann speak. The intense interest Mrs. Mann aroused was indicated when the 26 working groups into which the Conference was divided turned in their reports. Each group had listed alcoholism as the major health problem.

MINNESOTA: A symposium on alcoholism for physicians will be held May 23-24 at the University of Minnesota's Center for Continuation Study. Sponsored by the Minnesota Department of Health, the conference will feature such speakers as Dr. Lorant Forizs, clinical director of the Florida Alcoholic Rehabilitation Center and former clinical director of the North Carolina Alcoholic Treatment Center, and Dr. R. Gordon Bell, director of the Bell Clinic in Willowdale, Ontario. The main theme of the symposium will be treatment of the alcoholic.

NORTH CAROLINA: Those teachers who wish to attend the North Carolina Summer Studies on Alcohol had better send their applications in immediately. The Summer Studies will be sponsored again this year by the NCARP for teachers and prospective teachers in the state. The dates and places are: North Carolina College, Durham, June 10-21; East Carolina College, Greenville, June 17-27; A & T College, Greensboro, June 24-July 8; Appalachian State Teachers College, Boone, July 22-August 2. Course of study will be aimed at better understanding of the physiological, sociological and psychological problems arising from the excessive use of alcohol. By understanding these problems, North Carolina teachers will be better equipped to teach facts about alcohol to youngsters. Each course offers three quarter-hours college credit. Write for an application blank to any one of the four colleges listed above.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

I AM happy to announce that again this year we have been able to award scholarship grants to selected persons who wish to attend the Yale Summer School of Alcohol Studies.

As in the past, there were far more applications this year for these scholarships than the number we were able to grant. It has been pleasing to us to notice that each year the interest among professional people has not only been maintained, but increased, and our applications are almost totally from the professional person whose work normally brings him into contact with problems associated with alcohol or who is concerned with education and prevention of alcoholism.

1957 Recipients

The recipients of the 1957 scholarships and their professional status are listed as follows: Reverend Robert L. Bame, Southern Pines Methodist Church, Southern Pines; Barbara L. Blackwell, Health Educator, Alamance County Health Department, Burlington; Thomas A. Bland, Assistant Professor, Southeastern Baptist Seminary, Wake Forest; Margaret A. Brite, Case Work Assistant, Camden County, Elizabeth City; Lucille C. Benson, R.N., North Carolina Memorial Hospital, Chapel Hill; Carlton R. Donald, student, University of North Carolina School of Public Health, Chapel Hill; Forrest B. Cudd, Principal, Brevard Elementary School, Brevard; Reverend J. White Iddings, Pastor of the First Lutheran Church, Albemarle; Norman B. Kyles, Assistant Superintendent, State Hospital, Goldsboro; Mary K. Logan, Supervisor of Southern Pines City Schools, Southern Pines; Hattie E. Liston, Educational Counselor, A & T College, Greensboro; Esther E. Martin, Supervisor of Bertie County Schools, Windsor; Floride A. Martin, staff nurse, North Carolina Memorial Hospital, Chapel Hill, Elton Morris, Senior Probation Counselor, Domestic Relations and Juvenile Courts, Mecklenburg County, Charlotte; Calvin C. Paschall, Principal of Kittrell Graded School, Kittrell; Gladys P. Riddle, Psychiatric Social Worker, Charlotte Mental Health Clinic, Charlote; Frances E. Setzer, graduate student, University of North Carolina, Chapel Hill; Georgia L. Smith, Instructor in Health Education, Elizabeth City State Teachers College, Elizabeth City; Clyde W. Swink, Senior Clinical Psychologist, Cumberland County Guidance Center, Fayetteville; James E. Rhodes, Health Educator, Forsyth County Health Department, Winston-Salem; Billy H. Vendric, Child Welfare Worker, Craven County Welfare Department, New Bern; and Minnie L. Yar-

(Continued on page 32)

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Psychodrama: Rehearsal for Reality

Using this new method, patients at the ARC "act out" some of the problems they will face at home.

EDITOR'S NOTE

THE American Psychiatric Association defines psychodrama as "A technique of group psychotherapy in which individuals dramatize their emotional problems."

Sometime ago it was decided to try this new technique with patients at the Alcoholic Rehabilitation Center, on an experimental basis.

It should be emphasized that psychodrama is not intended to replace the conventional group psychotherapy sessions, which have been the principal treatment method at the Center since it was opened. Rather, it is merely an adjunct to group therapy, helpful to some patients in achieving a deeper insight into their personality problems.

BY JANET HAAS

ON February 28, 1956, an uneasy group of patients and therapists sat in a tentative circle facing one another on the first day of our psychodrama therapy program. It was difficult to tell who felt the most at sea, the most uneasy about the outcome. I know that we as therapists felt that we were pioneers starting out across a large unexplored territory with only the vaguest kind of map to guide us. We would meet many unforeseen hazards along the way, but many strokes of great good fortune would also be our lot.

What was going on in the patients'

Miss Haas is a clinical psychologist on the staff of the Butner State Hospital and the NCARP Treatment Center.

minds can only be guessed, but I feel fairly sure that none of them knew what "all this psychodrama business is about anyway", what might be expected of them, and most painful of all, what might be revealed of the secret fears and anxieties, the hurtful shyness and feeling of inadequacy which had held them in bondage for so long.

Now, sixty session later, we have come a long way together, all of us, in growing to understand the process of psychodramatic group therapy with alcoholic patients—the tremendous benefits that can arise from it and the equally tremendous anxieties which develop unspoken and paralyze a patient as he finds himself on the threshold of representing his true self before others, stripped of the social pretenses that we all put up, unable to whistle in the dark because everyone is listening for the real music beneath the false notes. Now, sixty sessions later, what was at one time a tentative hope that psychodrama might mean something at the Alcoholic Rehabilitation Center has grown into a staunch conviction that psychodrama can be a most realistic approach toward helping alcoholic men and women on the verge of re-entering society to cope with the complex and myriad problems which beset them.

Rehearsing Life

Few of us would care to jump into a new problem situation without learning as much as possible about what might be involved in it; few of us would dare to play a part upon a stage without adequate rehearsal. Psychodrama is a form of group therapy in which the realities of life are focused for a short time within the group, where the future can be brought into the present and dealt with in anticipation, and the past can be brought into the present as means of discovering one's own hidden motives.

Instead of employing the usual group therapy techniques of discussion, psychodrama involves the participation of the entire person. It takes the material out of the purely intellectual level into the level of ultimate emotional reality with which we all must deal. Typical situations, past, present or future, are actually acted out upon the psychodramatic stage. The person or persons involved, as well as the silently participating audience, has an opportunity to discover levels of feeling within themselves and new capacities for dealing with complex situations without that old familiar crutch, alcohol. Although sobriety is the immediate goal of the alcoholic and of this treatment center, we all know that in order to maintain sobriety, the very problems which led a man to seek refuge in alcohol, to seek support for shattered self-confidence in the bottle, will bring pressure upon him again and again with increased anxiety and tension, unless he can find newer and more adequate ways of meeting these old situations. Psychodrama affords just such an opportunity, an opportunity to try out plans for the future without having to accept the consequences which might arise from a false start.

Another Chance

In psychodrama, the "writing" is never done with indelible ink, so that if the subject of a psychodramatic scene finds out that he has made a mistake and brought unfortunate consequences upon himself, he can keep trying until he chances upon the more effective solution to his problem. He is not alone in this venture, for not only does the therapeutic staff assist him in creating and evaluating the dramatic situations which arise, but also the other pa-

tients throw in their comments based upon a cross section of personal experience, some of which prove to be more valuable to the patient working out his problems than any textbook suggestion could ever be.

Stage Is Set

Psychodrama at the Alcoholic Rehabilitation Center is carried out in the lounge in the female section, large enough to permit moving about and yet small enough so that we really feel like a group. In its ideal form, the psychodramatic stage is a circular one on three levels, and an intricate system of colored lights creates the illusion and the mood of the whole range of human emotion. At the A.R.C., we have to be content with an open space in the middle for the stage and red overhead lights to indicate that a dramatic session is in progress. As the group gathers amid much joking and uneasy laughter, and settles down expectantly, no one knows just what this day will bring, what this session will evolve. Under the direction of Miss Roberta E. Lytle, Psychiatric Social Work Consultant for the N. C. A. R. P., and with the assistance of Mrs. Nancy Webb, Social Worker, Rev. Roy Barham, Chaplain, the attendants on duty and myself, what was formerly a roomful of separate individuals becomes a group whose attention is more and more crystallized on a common theme.

The initial phase, called the "warm up", is important because of the constantly changing nature of our group, due to the fact that patients come and go at the end of their twenty-eight day stay. We never have exactly the same group on any two consecutive weeks. And so we must learn to know one another all over again each time, to find out the area of our common feelings, of our common preoccupations and needs.

The evolution of psychodrama is truly a group process, spurred on and led by the director. It is the creation of all members of the group who contribute to the atmosphere even through silence or open resistance. Nervously, the various members of the group look around at one another expectantly, hoping to find that someone else will seek a solution to his problem and that the dreaded spotlight will not fall upon him. Some try to be as inconspicuous as possible behind a post while others try to hide their deep concern behind indifference and even ridicule. For an alcoholic is basically an exceedingly shy person although he seems friendly and outgoing; a person really lacking in self-confidence although at times he appears to be cocky. Beneath his sneer of "ah, this is kid stuff!", there lies the timidity present in us all to some degree, that reluctance to show ourselves to others as we really are, and particularly to see ourselves in full honesty as we really are. However, knowing that what we really most deeply dread is often what we most deeply need, we press on, searching for the problem which will mean the most to the group, sometimes suggesting typical situations which have occurred again and again and sometimes waiting until an individual suggests a problem out of his own life situation.

Employer Problems

One of the most frequent problems which we encounter and deal with is centered in the area of finding oneself a job and building back a place in the community upon return from Butner. Time and time again, groups have examined and re-examined the difficulties of approaching an employer and asking him for a job with the knowledge of a long record of lost jobs and hospitalizations due to alcohol behind them. Usually the

situation is set up with two patients to play the role of the employer and the would-be employee. The applicant for the position enters the situation determined either to make a clean breast of his alcoholism or to try to cover up this fact in order to be more sure of obtaining the job. If, for example, the patient has decided that he will conceal his alcoholism, the scene is set up in the employer's office and he enters to make his application and neatly sidesteps the employer's questions about his previous occupations and reasons for leaving. At the suggestion of the director, a double will then come in for the employer, to be the employer's other self, as it were, to voice his unspoken doubts about the job applicant's story and his suspicions as to the man's honesty.

Spoken Uncertainties

Often a double will be sent in to help the would-be employee, to speak up the uncertainties of a pretender, the feeling that sooner or later he will be found out and it will go hard with him. However, the arguments in favor of concealing one's alcoholism being more convincing to the patient playing the role of the would-be employee, he often continues until the end of the interview in an attempt to impress and deceive the employer. By this time, the audience has become involved in the situation and comments from the sidelines are heard. Some are urging the man applying for the job to be honest about the whole thing for his own peace of mind; some are warning him that if he does, he will never get the job; some urge the employer to speak up his silent suspicions; others urge the employer to give the poor guy a chance even if he is lying, and so on. In the analysis which follows, groups come to different conclusions as to the best course to follow but they go away with an increased awareness of all the possibilities involved and the pros and cons of each course of behavior.

In just such a way do we meet other situations, presenting possible eventualities to the patient and allowing him to deal with them spontaneously, drawing upon his own personality resources for an answer to the problem, secure in the knowledge that this is, after all, only psychodrama and no ultimate reality. Often, we find it of great benefit to have the patients change parts. To allow a man to change parts with the person playing his own wife not only gives us all a clear idea of what his wife is like, but lets him stand in his wife's shoes and see how it might feel to be married to him. This is often an eye opening experience for many patients who have become so wrapped up in their own problems that they cannot put themselves in other people's places and see how they feel.

Independence-Dependence

As we look back over the work we have done in psychodrama at the A.R.C., we find that there are many common problems shared by our patients, problems which when solved by one in front of many, bring some degree of insight to even the most silent observer. For example, an alcoholic often lives under the shadow of a domineering person who tries to treat him like a child, to over protect him "for his own good." Although in all of us there is some yearning for this dependency, there is often an equally strong yearning for independence, for growth and maturity. Finding these two urges incompatible in the same person, the alcoholic often tries to resolve this conflict through drinking. By means of psychodrama, however, we have found that effective techniques for

dealing with domineering people can be developed. In the first place, by rehearsing a more self-assertive independent pattern of behavior in the relatively sheltered environment of the therapy group, the alcoholic can gain strength to stand on his own two feet when he gets into the actual situation. Then, too, as he hears an auxiliary play the role of this person who is attempting to rule his life really speaking the feelings which underlie such a desire, and particularly as he reverses roles with this person and tries to see through his or her eyes, there comes to him an understanding of the other person which is the most valuable possession for personal growth.

Case In Point

I remember the case of a woman very much domineered by her older sister who had had to take their mother's place and raise the younger children; she had done so with the air of being a martyred saint, and had taken out her anger and resentment on our patient. Always terrified of her sister, our patient was absolutely unable to talk back to her because all she could see in her was strength, power and hostility. When I was asked to play the role of this sister and was asked to talk aloud to myself (soliloquize), my real feelings when my younger sister (our patient) was born, I found myself feeling, as this young sister, that I had been deprived of a great many of the childhood joys that the younger children had had because I had had to be an adult too early. I began talking about this, about my resentment and my feeling that I wished I still had somebody to take care of me, my feeling that I was not really all that strong and should not be expected to be. Our patient was sitting beside me listening intently and I believe truly this was the first time in her life it ever occurred to her that her older sister who seemed like a terrifying primitive force, could ever have a fear herself, an anxiety, a weakness.

Reaches Understanding

In this way, then, we can approximate reality at least, can try to show ourselves and others in truth and not dressed up for a costume ball. Fortified by the feeling that this frightening older sister was only human after all, our patient was able to tell her upon discharge from the Center all of the pent-up hostility and fear which she had held within her for twenty years, secure in the fact that they were two human beings dealing with one another and no longer a child dealing with an all powerful older woman. Sometimes, only when we bring our feelings out in the light of reality can we see that while they may have been appropriate to our situations when we were children, they no longer apply to us as adults.

We are still growing. We like to think of psychodrama as a process ever changing, a creation not only of the therapists but of the patients. We hope with the passage of time to learn more about the anxieties which psychodrama raises and the best ways of dealing with them, and more fruitful and creative ways of giving the alcoholic returning to society, the same warm feeling under his belt, the same sure sense of confidence that he once got out of the bottle. For in a very real sense, psychodrama does not give to an individual anything that is foreign to himself. It only helps him to discover within himself new resources never before dreamed of, new capacities for understanding of himself and others, new bravery and new warmth. He is helped to be aware where once his eyes were shut, to speak where once his tongue was stilled, to live where once he had existed only.

Indescribable physical and mental suffering

CREATION

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A HANGOVER is something that is more or less familiar to us all. It is the inevitable reaction of over-indulgence in alcohol.

The first, and most shocking, fact about a hangover is the worst. There is no cure for it; it cannot be sidestepped, bypassed, run away from, ducked, dodged, skipped, jumped, avoided or gone under or over. It must be gone through.

To create a really terrific hangover, one needs an amazing amount of practice. A hangover is, at best, a revolting ordeal and should not be gone through all at once. There are ways and means of postponement. A little more of the same will usually delay the fatal day, or, as we like to think, delay the day of the hangover till a more propitious time.

One would assume the second-day hangover to be twice as bad as the first-day sort but one would be in error. The second-day variety is approximately 20% worse than the first-day kind. After the third or fourth postponement, the delayed action can be had for as little as 10 to 15%.

A long-continued siege of postponements is of great value to the ultimate perfection of this creation, but in so doing we acquire a bill of staggering proportions; a bill that can

are the price paid by the alcoholic for the

OF A HANGOVER

only be expressed in terms of the largest denominations; a bill that cannot be paid in money. It can only be paid in physical suffering and mental anguish.

Money can procure the services of the medical profession; medical science can alleviate the physical pains, in a small way; but it can do little to ease the mental agony: the remorse, the resentments, the self-pity, the self-condemnation, the disgust, the feeling of impending disaster, the feeling of futility, the degradation, and the aloneness, the awful aloneness.

As we progress in the perfection of this creation, we have many and varied experiences. We progress from the mild, queasy sort of hangover to the brown whimpers, to the whips and jingles, to the flapping woo-woos, to a nameless condition—an indescribable sort of thing that defies words or the imagination.

On this day we awake with a splitting headache; the top of the head feels like a boil ready to pop. A throbbing, pounding ache keeps time to the beating sensation that is literally all over the body. The mind and the nerves are screaming for another postponement. The body refuses. The mind and nerves are insistent, more of the same is administered, the body promptly refuses it. We are at war within ourselves. The attempts of postponement are thrown back and we face the staggering bill of retribution.

Slowly we emerge from the fogs and vapors. Nerves are screaming for relief. A tingling, itching sensation, like bugs or ants crawling, steals over the skin. We are nauseated, jumpy, nervous, cross, irritable. A ringing is in the ears, dancing lights in the eyes. Eyes don't focus. Get out of bed, weak, legs wobbly, won't coordinate, shuffle and stagger through a doorway . . . an intangible something whips from in front of the eyes, leaving a sensation that we narrowly missed colliding with an unknown thing, a thing that was unreal, a thing that was frightened at our approach. Sneak back in bed and draw the covers tight around us. We are unbelievably cold. Rivers of sweat stream from every pore. Stare about the room and the fleeting intangible things are darting in and out of the dark shadowy corners, behind the chairs, under the bed, moving with the speed of lightning.

The buzzing and ringing in the ears, like chimes and music, whispering and muttering, bells and bands are all jumbled together in a bedlam of sounds, far away and indistinct.

The heart pounds with a thudding beat that jars our entire being and the hammering in the top of the head, every nerve and fibre of the body, keeps time to this jarring beat.

The room has suddenly come to life. The chairs are waving and shimmering. The floor has become a waving sea, swelling and falling, an endless procession of wave after wave flowing out of the wall and vanishing into the opposite wall. Little red-coated men dance on the ceilings and walls, little red-coated men with wooden shoes and peaked hats, dancing in time to this eternal throbbing pulsation.

We close the eyes, dig fists into them to shut out these scenes. A panorama of jumbled visions starts moving in front of the closed eyes, like a jerky and blurred motion picture . . . scenes of lakes and waters, woods and trees, weird creatures, half man and half beast, some pleasant and some horrible.

Open the eyes to the endless waving, throbbing of the room, to this sea of waving floors and shimmering chairs, dancing men and dancing lights . . . small heads with glittering eyes and elongated bodies ride the waves, twisting to the motion of this sea of floors. From out of the wall comes this endless flow of waves, of heads, of elongated bodies with glittering eyes, to dance and wave slowly across the room and vanish in the opposite wall.

The splitting headache, the thudding beat, the buzzings, the ringings, the whisperings and whimperings, the murmurs, the chimes, the bells, the bands and the bedlam of sounds join forces, swell in volume and march to the top of the head in one concentrated effort to escape. They launch the attack in one great pounding attempt. With every beat of the heart the head swells outward to ease the terrific force of the attack, expanding and contracting as the hammerings continue, swelling to a grand finale that can only explode and erupt as a volcano.

As a sober alcoholic I hope I shall never forget this terrible creation—a hangover.—*B.W., Los Angeles, Cal.*

ON ALCOHOLISM

ALCOHOLISM is often mistaken by the casual observer for willful behavior rather than evidence of sickness, because of the antics of the person who is under the influence of the drug—alcohol. But given a little thought, it is apparent that the combination of symptoms we call "alcoholism," is a sickness, difficult to understand because of its complexity, but easy to recognize because of its deteriorating effects on the sufferer. Time was when illness or disease was concisely described and attributed to a single causal factor—Appendicitis was due to an inflamed appendix, pneumonia was due to a pneumonia germ, and so on. In recent times, however, a new concept of illness and disease has developed. This new concept is often called the "psychosomatic" concept and many illnesses hitherto thought to be simple in nature are now called psychosomatic illnesses. Psychosomatic is a big word but simply it means a "mind-body" illness, one that affects mind and body jointly. Alcoholism is a psychosomatic illness, the history of its development can be recognized and traced like any other illness and it can be treated successfully.

—From the NEWSLETTER, published by The Alcoholism Foundation of British Columbia

Life Without Liquor

The benefits of sobriety and a more normal way of life will surprise the alcoholic who achieves it.

BY THE LATE ROBERT V. SELIGER, M.D.

DO you want to stop drinking? Are you completely sincere in your desire to stop once and for all?

Put it another way. Do you finally realize that you have no choice but to stop? Are you convinced that you would rather quit drinking than go on the way you are?

Perhaps you feel that quitting is an almost impossible task, and that you are "not up to it." But reflect for a moment on the fact that present-day medicine, for the first time in history, can understand and help many alcoholics.

The alcoholic is similar to other sick people in that he very often doesn't know that he is ill and even when he does, he frequently postpones doing something about it. But there is this difference: the vast majority of alcoholics haven't the faintest idea where to go for help, or even any realization that, in many cases, they *can* be helped.

What is your present situation? Things are going from bad to worse, but you can't seem to halt the process. People have plenty to say about your drinking but they are hardly understanding or helpful. Perhaps your friends or your relatives entreat you to "reform". Perhaps they plead with you to go slow and drink sensibly. Perhaps, in sorrow or in anger, they call you a weakling or a drunkard. You hear that you are dissipated, that you are going to pieces. Some-

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times you feel that it is true. You grow angry and depressed. You decide to have two or three stiff drinks to forget your troubles, clear your mind, and think things over. And you are off again.

When you drink too much you sometimes tell yourself alibis. You say the liquor "hit you" that particular evening because you were tired, or upset, or not feeling well, or a vague something-or-other was on your mind. You decide to slow down. But you don't.

Help Is Available

We will assume that this situation has finally become intolerable, that you earnestly desire to be cured and that you now have no mental reservations. Unlike the alcoholics of all past generations, you can go to a doctor for understanding and help. In the past, alcoholics were considered doomed—barring a miracle. An insignificant percentage managed "to take the pledge" and keep it, perhaps with the aid of a temperance society, or as a result of strong religious or family influences. Even in many of these cases, however, the former alcoholic—although luckily ridding himself of the harmful effects of liquor—still suffered from the underlying disorder which originally caused him to drink abnormally.

Medicine itself found alcoholism one of its most baffling problems. For centuries it adopted a hands off, fatalistic attitude toward the problem of abnormal drinking. This feeling of "once an alcoholic, always an alcoholic," persists, understandably, in a great many circles today.

But medicine finally began to grapple seriously with the problem of alcoholism because it became increasingly apparent that it had some connection with mental and emotional disorders. Early experiments involved much trial and error. One method that was tried, and found wanting, was the attempt to taper off the alcoholics, often in an effort to transform them into moderate drinkers. When a medical pioneer named Forel, late in the 19th century, began to treat alcoholics without alcohol, he was laughed at by people who said his patients would die like flies.

Many early methods of combatting alcoholism involved mass treatment, or "alcohol drink cures." These were based on the mistaken theory that all types of patients could be treated alike. There was also the program of brief periods of desaturation for the drinker, which merely meant keeping the alcoholic away from liquor long enough to sober him up and quiet some of his jitters and then turning him loose for another bout with liquor. (Unfortunately, these methods still have not altogether died out.)

Even American psychiatry, with few exceptions, long looked upon alcoholism with more or less hopelessness. It is only in the last few years that a growing number of psychiatrists have realized that a carefully selected number of patients can be guided to total abstinence by dispassionate and individualized treatment.

Medical Advances

Any alcoholic who is not too far gone can now take advantage of this new development in medical knowledge. The benefits of abstinence will surprise the alcoholic who achieves it. Odd as it may sound to the abnormal drinker in his present state, there is a good deal to be said for the normal life, devoid of the artificial elements created by a misused narcotic. The abstainer is neither a martyr nor a hero.

In a sense, the swift disappearance of the typical alcoholic miseries is one of the earliest and most striking benefits of abstinence. Their absence

feels good—in the same way that it feels good when a prolonged pain ceases suddenly. No more dread of hangovers. No more alcoholic depressions and remorse. An end to the nervous horrors, the jitters, the headaches, the nausea, the butterflies in your stomach.

Perhaps you have gradually come to take all of these miseries for granted. They seem to you almost usual to the course of life. The fact that some people do not suffer from them may seem as remote and impersonal to you as the aromas in a Persian market-place. Fellow humans who have good nerves, energy and ambition, strike you as a little obnoxious. And anyone who stays in pretty consistently good spirits seems disgustingly healthy and even a bit of a bore.

You have simply forgotten what the world looks like when not seen through an alcoholic fog. Abstinence is not a panacea for all human ills but it means that you can again really enjoy food, get restful, untroubled sleep, and wake up without hating the fact that you have become conscious again. It nearly always means better health, more energy, renewed ambition, happier relationships with those around you. You can expect your work to improve and, other things being equal, your earnings to increase. A not unimportant item for most people is the saving of the money that alcoholism costs.

Interests Change

One of the most fundamental satisfactions in convalescing from alcoholism is the rapid acquisition of new interests in life. If you are like most alcoholics, your old interests have been gradually slipping away and you are no longer really keen about much of anything. You have lost most of your zest for intellectual pleasures as well as for the normal forms of entertainment and relaxation. This zest will come back to you, if your mind has not already been ruined by alcohol. Perhaps you do not believe this prediction? If you don't, it is rather eloquent of the state that you are in, and you will have to accept it on faith—supported by the fact that the world contains a great many people who are intensely interested in a great many things.

Minor Satisfaction

Another satisfaction, minor but definite, is the fact that sobriety gives you a slight edge in some ways over even the social drinker. It would be silly to over-emphasize this advantage and the authors are certainly not campaigning against social drinking. The social drinker gets a lot of fun and often numerous benefits from his drinking, and whatever relatively slight penalty he has to pay for the results he considers an excellent investment. Nevertheless, it is only truthful to point out that social drinking has some disadvantages and the alcoholic who has become an abstainer would be more than human if he did not take some satisfaction in them.

Even social drinkers sometimes drink too much, waste time, lose sleep and spend more than their budget for entertainment can stand. Occasionally they say indiscreet things and make otherwise unfortunate remarks. There are times when they try to mix drinking with business dealings or important personal matters and find that the consequences are unhappy—because alcohol has dulled their perceptions or altered their moods.

Even so, the authors are more than willing to admit that these are minor and normal hazards to an entirely justifiable indulgence. It is solely

(Continued on page 32)

What are the compulsive eater and the alcoholic seeking in their excessive use of food and drink? What lies behind

Alcoholism and Obesity

BY CLAIRE CHENEY

HOW often have you heard the alcoholic say, "This is my last drink. After this, I'm through"? How often have you heard the overweight person say the same thing, only he phrases it, "I'll go on a diet tomorrow. I promise myself this is the last time I'll eat too much"? Both the alcoholic and the overweight person who is a compulsive eater are actually unable to control their individual need for drink and food, in spite of many promises, regrets and self-incriminations. One finds in eating, the other in drinking, temporary fulfillment of their desires. They are both suffering from underlying emotional disturbances of which excessive use of food and drink are only symptoms.

To the alcoholic, whiskey provides release from anxieties and tensions he cannot tolerate. The magic of the bottle becomes his escape method. It offers to him the easy way out of life's problems. Is it possible that alcohol is not the only means of securing such pleasant reactions? Yes. Medical case histories have scores of examples of people who have found escape from everyday tensions and worries through some means other than alcohol. A case in point is compulsive eating, where no organic cause has been detected.

Exaggerated Values

Alcoholism and compulsive eating resulting in obesity are closely tied together. The alcoholic and the obese person are striving for similar goals. Psychiatrists say that the obese person has an exaggerated value of food above that of its caloric value. It represents love, security and satisfaction: it provides apparently simple means of relieving the ever-present nervous tension. When the obese per-

son is worried or upset, he tends to eat more than usual. He may stuff himself at dinner, only to return to the refrigerator an hour later and eat everything in sight. He cannot control his compulsion to eat. He may hate himself while in the throe of this eating binge, but is helpless in the face of it. He *needs* to eat for some reason he doesn't understand. Even when a compulsive eater knows that each calorie he adds to his already large body will take years off his life, he cannot control his desire for food. He is unable to follow the most highly supervised reduction diet.

When the alcoholic is worried or tense, he finds relief in a drink. He may also hate himself while on a drinking binge, but is unable to control his desire for more and more liquor. He, too, *needs* to drink for some reason unknown to him, even when he realizes that his alcoholic condition can cause him the loss of everything heretofore valued.

You might say that the emotional needs of an obese person and an alcoholic are similar. In some cases, substitute food for alcohol and you may not be able to tell which person is suffering from which illness. The alcoholic seeks comfort in overdrinking alcohol in the face of failure and frustrating experiences: the compulsive eater seeks his comfort in overeating.

The alcoholic fares worse in society than the obese person. Eating is socially acceptable, whereas excessive drinking is not. The alcoholic may lose his job, his family and his friends because of his alcoholism; the obese person is less likely to suffer these losses because of his obesity. People tolerate the obese person, may even smile or make jokes

when they see, for instance, a fat person struggle to climb a steep flight of steps. It is not funny, however, when an intoxicated man or woman strains to make that same climb. It is embarrassing, both to the alcoholic and to the people watching him. The form the alcoholic has taken to help relieve his tensions is looked down upon; the form the obese person has taken to relieve the same tensions is tolerated. To society grossness of the body is a less offensive condition than the loss of control over mind and body.

Case History

Dr. William Parson and Dr. K. R. Crispell, psychiatrists, have published a case history of a compulsive eater whose background, tensions and anxieties could closely resemble those of an alcoholic.

"Mrs. L. T., a 35-year-old white woman, was admitted to the University of Virginia Hospital on May 24, 1951, with the chief complaint: "I can't lose weight".

"A routine history revealed that she had been obese for at least twenty-five years. During this time she had consulted at least ten physicians, a chiropractor and an osteopath. She had been given a diet by each physician and would lose 10 to 15 pounds each time she was given a new diet. She would become discouraged after two months of dieting and fail to make return visits. She had been told by her last physician that she had "glandular trouble" so was referred to our service.

"Physical examination was unremarkable except for a weight of 290 pounds. Routine laboratory studies were all within normal limits.

"Our first two interviews with this patient were carried out on the ward and she told us that she was happy, she enjoyed her family, and knew of no reason why she should be tense or anxious. She was then interviewed in our office on five separate occasions. The following facts from her life situation seemed important. She was the oldest of five children, and stated, 'I have been fat as long as I can remember. Daddy was a wonderful man but Mother ran the family.' She remembers being encouraged to eat at each meal and at age 10 her father spoke about her to their guests as 'his big fat baby.' Mother was extremely strict and did not allow her to date or have anything to do with boys. She remembered "getting something to eat" when her mother refused to let her have a date. All decisions were made by her mother as to her activities, clothes, time of sleep and the like. She married at the age of 19 a man she had known only a short time. She became pregnant soon after marriage, but her husband demanded that she have an abortion which she did with a marked feeling of guilt. Following the abortion she gained from 135 to 219 pounds in a six-month period.

"The patient is constantly worried that she will hurt people, that her husband will lose his job, that 'I will do something to hurt Mama.' She admits that at these times when she is upset and anxious she 'feels better for a while' after she eats. As a result, she often has 'a little sandwich and a glass of milk' every two or three hours. It also became quite obvious as the discussions continued that she was not too much concerned about her overweight. Her main concern at this time were periods of marked depression in which she cried a great deal and was unable to carry on her usual household duties."

Drs. Parson and Crispell had the following comment to make about this case: "The patient presents many of the features that have been emphasized as being of importance in the development and mainten-

ance of obesity. She is immature, passively dependent, insecure and almost helpless in meeting everyday problems. Food to her has taken on a special value in that she feels 'better for a while' after she eats and at the present time, it offers a way to relieve anxiety and tension."

How like the alcoholic is the obese person in his striving for release from a life he has found unbearable. Whenever Mrs. L. T. was thwarted, as when her mother refused to let her date, she "got something to eat." Whenever she worried about her husband and her own feelings of inadequacy in her relationship with her mother, she "felt better for a while" after she ate. Eating to Mrs. L. T. was a synthetic substitute for love and approval from her associates and from herself.

Contrasting Case History

Here is a typical case history of an alcoholic who sought treatment because, "I can't quit drinking." The history was written by psychiatrist Edward A. Strecker, M. D. Contrast this alcoholic's life to that of Mrs. L. T.

"John H.'s mother was over forty when he was born and since he was the only child and probably would be the only child, she became determined to keep and protect him at all costs. From his earliest days he was coddled and pampered. She fought his battles for him; made his decisions for him; would not let him take an active part in sports; picked out his friends, his clothes, and even the books he read. In short, she dominated him completely.

"From the time John was old enough to walk and talk he was shy and timid. He wanted to be accepted as 'one of the boys', but his desires to conform in such things as dress, play, and general activities in and out of school were completely and thoroughly thwarted by mom. As a result, he was picked on and bullied. He was called a sissy and a mamma's boy. He was teased and laughed at. Naturally his shyness increased. He fast developed all the traits and behaviors of an introvert in spite of the fact that he wanted to be otherwise.

"The story was no different when he entered an eastern university. He did find acceptance within a certain group, but they were very much like himself. Then, during his junior year, he made a discovery—after a few drinks he found that his shyness seemed to fade. After a few more drinks he felt he could meet people, talk, and enter into things. He embraced alcohol as a new-found friend and protector—it solved his problems for him, it dulled the sharp edge on his knife of reality, it provided a protective shell that mom no longer could give him.

"He didn't realize it then, but by the time John graduated from college he was well on his way to alcoholism."

John H., like Mrs. L. T., was immature, dependent and unable to face

IT is well to remember that the desire to eat in most obese patients is an unconscious drive and is as impossible to control in the obese patient as is diarrhea in the patient with mucous colitis or the intake of alcohol by the chronic alcoholic.

—From "Obesity" by William Parson, M.D. and K. R. Crispell, M.D. in OUTLINE OF ABNORMAL PSYCHOLOGY

his problems. Mrs. L. T. discovered an outlet for her frustrations, overeating, early in life. As a child, food had great importance for her, and as she grew older, she found that by eating great amounts whenever she felt the need, her sense of inadequacy and frustration was temporarily relieved.

John H., however, didn't find his emotional outlet, alcohol, until later in life. He was in college before he realized a few drinks could drown his shyness and transform him into an out-going, socially accepted person. The flaw was that neither Mrs. L. T. nor John H. could control their individual compulsions for overdrinking and overeating.

The emotionally disturbed person who finds in overindulgence of alcohol or food a means of escape is in reality seeking gratification for some element which he feels he lacks, be it love, security, approval, etc. Alcoholism and compulsive eating are only symptoms of some deep, underlying emotional problem. The escape methods that the alcoholic and the obese person have chosen in their search for gratification are not to be considered independently. There are reasons *why* an alcoholic drinks excessively. There are reasons *why* the obese person overeats. However, not in every case of obesity is an emotional disturbance present, but many clinicians maintain that emotional disturbance is present in all cases of alcoholism.

Once the alcoholic and the obese person understand why they overindulge and through help from professional sources come to better understand their own personalities and behavior, they stand a good chance of freeing themselves from their compulsions. For true fulfillment and relief from tensions cannot be found in food and drink.

HEALTHY RESPONSE TO FRUSTRATION

IF an individual is healthy, if he has learned earlier in life to master frustration, in the face of new frustrations his reaction is one of renewed effort and he may achieve his goal some other way, accept the impossibility of the situation or work out a substitute gratification. These would be healthy responses to frustration.

—Lewis L. Robbins, M.D. in STRESS SITUATIONS, edited by S. Liebman, M.D.

YOUR ATTITUDE CAN MAKE THE DIFFERENCE

ATTITUDES make a great difference in the outcome of life. The person who is trying always to escape from life's unusual demands will never find the outlet through them to the larger life beyond. Every crisis is an opportunity for discovery. No one weathers the storm of a turbulent emergency without realizing powers within himself he never knew he had; friends whose presence and devotion he had not recognized; resources which would never have been utilized if a desperate hour had not called forth new explorations in the reserves which life holds back for emergencies.

—From "PATTERN FOR SUCCESSFUL LIVING" by Fred P. Corson

Unsolicited Love... Rx for Alcoholism

BY ROY B. BARHAM
CHAPLAIN, ALCOHOLIC REHAB. CENTER
BUTNER, N. C.

The best prescription you can give the alcoholic is genuine love.

MEN of science and faith have rediscovered love as the therapy for the treatment and the prevention of alcoholism. A physician I know who has been treating alcoholics for years says, "the alcoholic drinks because he needs a power greater than himself," and that power is love.

Love, if it is genuine, is its own reward. It is a false concept of love when one thinks that he should be paid for it. Love is a quality of self-forgetfulness that is not primarily concerned with getting along and being rewarded—not what one is to get, but what one is to give.

Illness of body or mind, frustration, boredom, irritability, or depression, is a warning to us that we do not love one another.

The psychiatrists at the State Hospital at Butner are convinced that the great taproot of mental illness is lovelessness. They consider alcoholism a symptom of poor mental health. Psychologists and social workers who treat emotionally upset children have found that it makes little difference whether a child is fed by schedule or whether corporal punishment is used so long as the child is loved. Sociologists say it is the answer to delinquency, criminologists say it is the answer to crime, and political scientists say it is the answer to war.

The kind of love I am talking about it not the kind we see depicted in the movies and in fiction. It is the love which Jesus knew by insight; the simplest and most complex attribute

of man, also the most misunderstood.

The way we use the word "love" shows how little we understand it. We say, "I love food, I love automobiles, I love dogs, and I love my wife." We use the same word but do we mean the same thing?

Doctors are no longer recommending T. L. C. (tender loving care) just for babies. They are saying to the families of alcoholics that tender loving care is what it will take to bring relief to their members who are suffering from compulsive and uncontrollable use of alcohol. But the trouble is, most people, even many of us who think we are happily married, do not know what love is.

So many of us husbands are like the man who says he "loves oranges". If an orange could talk back to us it would say, "What do you mean, you love me? All you want is to squeeze me, take the best out of me—and then throw me away." I am sure our wives feel like oranges sometimes.

If we are to understand what love really means and what Jesus meant when he said "God is Love", we must get rid of a great deal of pseudo-love. We must get rid of all feelings of "I desire", "I want to possess", "I get gratification from", "I exploit" or even "I feel guilty about".

Pseudo-love

Our indulgence of children is a form of pseudo-love. My experience working with delinquents at the Umstead Youth Center convinces me that most of these young boys have received only indulgent pseudo-love, a guilt-ridden attitude which "buys off" a child rather than strengthens his growth and responsibility. Rehabilitation of delinquents is an attempt to undo the damage by parents who have confused the word "love" with "appeasement".

The common forms of pseudo-love found in the histories of our alcoholic patients are over-solicitousness and over-protection. If we are not careful we may be fooled by them and allow them to pass, not only for love, but for extremely high forms of love. They are not love at all. The husband who is jealous of his wife may not love her at all, but he may be restricting her. The mother who holds the hand of her seven-year old son as he walks a rock wall may be over-protecting him because she is quite antagonistic towards him and if he should fall and get hurt it might be like wish fulfillment.

What Love Is Not

Love is not possessiveness. It is not making another person over into your own image. It is not dependency, like the parasitic love of a tick for the dog's ear. It is not self-sacrifice. It may at times involve sacrifices, but the full time sacrificers, whether they be parents, wives or just plain do-gooders who go around wearing halos of self-deprivation are more often than not motivated by guilt.

Love Defined

I have said what love is not, now I want to try and define what real love is. The kind of love that will prevent anyone from becoming an alcoholic and the kind that will bring relief to those who are suffering from alcoholism. Dr. Harry A. Overstreet

Be not afraid of life. Believe that life is worth living, and your belief will help create the fact.

Friendship consists in forgetting what one gives and remembering what one receives.

says, "The love of a person implies not the possession of that person, but the affirmation of that person. It means granting him gladly the full right to his unique humanhood. One does not truly love a person and yet seek to enslave him—by law or by bonds of dependence and possessiveness."

Love has been described as the soil in which loved ones grow. It enriches them without restricting them. Love is a giving of one's self. Our marriage ceremony should say, "Do you give yourself to this man or woman," and not "Do you take this man or woman".

Institutions of various kinds have what they call routine treatment for various illnesses. If I were preparing a prescription for routine treatment of alcoholics, I would head the list with "Love Unsolicited". The alcoholic should be shown an attitude of love whether he has earned it or not. To prevent alcoholism or any other mental or spiritual illness, all of God's children must be made to feel that they are loved and there are no conditions attached.

Unwanted Child

A patient at the Center was an unwanted child, born out of wedlock, rejected by his mother and others with whom he grew up. He quit school at twelve because the older children called him "patchy". Having learned to use alcohol to relieve some of his uncomfortable feelings about himself, he became an alcoholic. Prior to coming to us he had been shot twice and he had sought out and beat up several of his former classmates who had said unkind things about the patches on his clothes. This young man realized that his continued use of alcohol to relieve his feelings could lead to disaster. Never having been loved, he could not love and having no religious training, he had not learned to forgive nor to accept forgiveness. The only way he could venture into the world of interpersonal relations was with the aid of alcohol to remove his inhibitions to associate with others.

Expressions Of Love

For many people love and sex mean the same thing. Of course, they are related. Sex is only one of the avenues of expression of love between man and woman. It is by no means the only one and certainly not even the major one. Much of the sexual activity of alcoholics has no relation to love and is only pseudo-love. Much of it is exploitation, aggression and possession—the use of one individual by another. This is no less true of the non-alcoholic wife or husband than it is of the alcoholic.

Sexual love ceases to be pseudo-love when the intimate relationship involves an integrating and meshing of personalities; a passionate interest in the other's dignity and worth. The ultimate in love may occur in a con-

ONE factor stands out. Man himself is the chief threat to man's mental health. It is not the ordinary vicissitudes of life but the complications man has added to them that make trouble. We could meet sex or fear or failure or competition without danger to our mental health except for the fact that man has added customs and meanings and threatening consequences to these ordinary problems of living.

From THE SUBSTANCE OF MENTAL HEALTH by George H. Preston, M.D.

genial conversation, looking at a sunset together, or listening to good music. Love does not exist because of physical contact. It comes into existence when two minds—two distinct personalities in a sense merge and begin functioning for one purpose, the affirmation of each other. The love that is present in an Alcoholics Anonymous group is this kind of love and that is why alcoholics find relief from their uncomfortable feelings sufficient to refrain from taking the first drink. That is why many members of AA say they do not care why they drink since they have found a way to stay sober and be comfortable.

I know that many of you are asking that if what I am saying is true why are there so many alcoholics and other emotionally disturbed people. It is because to love is not easy. Love is an achievement—quite a rare and important achievement. It requires as much desire to learn and as much practice to love effectively as it does to be able to create good music or great literature.

Love Unconditionally

If we are to prevent alcoholism in the generations to come we will do so by cultivating the ability to love unconditionally ourselves and teach our children to love the same way. In infancy a child's love is directed toward himself. He is overly concerned about his own comfortableness, both physical and emotional. If he is healthy, he gradually expands his capacity to love to include, first his mother and then his father, then other members of the family and finally the other people around him. If we could measure our prejudices of other individuals and groups, we would have a very accurate index of our ability to love.

I know some of you would like to have some lessons in the art of loving. I can offer no easy lessons. The only way to teach love is by example. By cultivating our own capacity to love, we teach those around us to love. The only ingredient that will nurture love in another is love; love from another who is not demanding or expecting anything in return.

If I were to say to the parents of alcoholics that the reason for their son or daughter's drinking is that they don't love them, I would have an argument on my hands. All of us would say that we love our children. But do we? We do not love our children just because we protect and snuggle them and provide for them. The animal does as much for its young.

How far do we humans go beyond the animals? To what extent do we affirm our fellows as people? How much do we respect their integrity? Their individuality? To what extent do we help them grow independently instead of smothering and possessing them? These are the measures of our ability to love. The kind of love I am talking about has far more healing power than any drug known to man. It is the kind of love that enabled Jesus to heal the sick who had faith in Him because of His love for them.

Before any of us can love another we must be able to love ourselves. It may come as a bit of a shock to some of you to hear me say that self-love is good—that we must love ourselves if we expect to be able to love others.

Self-Love Is Good

It may be hard for us to accept this after having been raised to abhor conceit and egotism, to detest selfishness, and to say that the trouble with Mary is that she loves herself too much. Yet isn't this what Jesus meant when he said "love your neighbor as yourself." I believe that he expected us to love ourselves or he would not have asked us to

love our neighbors by the measure of love we have for ourselves.

If I have confused you, let me say that selfishness and self-love are not identical, they are opposite. The selfish person does not love himself too much but much too little; he hates himself. This is his way to conceal his hate for himself.

The person who loves himself can be devoted to his work and still let go of it in order to relax. Such a person is aware of his bodily needs and sees that they are met. He realizes that he has possibilities and limitations and is able to live peacefully within his limitations.

Self-love of the kind I am talking about is a consistent regard for one's self as a human being and implies by necessity the same kind of love for others.

Patient after patient at Butner reveals a lack of self-love. If our patients could love themselves instead of carrying hidden burdens of self-contempt, we would not have them as alcoholics. And the way for us to teach them to love themselves is to accept them just as they are and make them feel that they are as important as we are, that their goal in life is as noble as ours and that if there is a difference in us it is in the method we have used. This is the kind of climate we strive to provide at Butner. This is the climate in which alcoholism can be prevented and treated successfully. It matters little as to the kind of treatment, but it does matter as to the presence of unsolicited love in the emotional environment.

What I have said about love and its use as therapy in the treatment and prevention of alcoholism can be summed up in the words of Jesus when He said, "A new commandment I give unto you, that ye love one another".

Love is patient and kind; love is not jealous or boastful;
It is not arrogant or rude; love does not insist on its own way. It is not irritable or resentful;
It does not rejoice at wrong, but rejoices in the right.
Love bears all things, believes all things, hopes all things, endures all things.— *Paul's letter to Corinthians*

NURSES' INSTITUTE ON ALCOHOLISM

They learned how important they are in aiding the success of the alcoholic's recovery.

WHEN an alcoholic has been hospitalized, the role the nurse plays is most important to the success or failure of the alcoholic's recovery. In a hospital setting, no other person comes into such close contact with the alcoholic patient as the white-gowned woman who administers aid to his mental and physical wounds. And since the nurse is in such a supportive position, it is imperative that she know complete facts about alcohol and alcoholism.

This was the theme of the 1957 Nurses' Institutes on Alcoholism held April 24 in Greenville, North Carolina, and in Asheville on April 26. The Institutes were prepared and arranged for those in the nursing profession who at some time or another had had or would have contact with the alcoholic patient. The Institutes were sponsored by the North Carolina Alcoholic Rehabilitation Program and the three state nursing organizations: the North Carolina League for Nursing, the North Carolina State Nurses' Association, and the North Carolina State Board of Health.

It had been found through past inquiries that many nurses have had little or no instruction about alcoholism as an illness. They see the affliction through the shadowy eyes of misconceptions and untruths. Since the nurse is so important to the welfare and recovery of the alcoholic patient, the Institutes were planned for the purpose of giving all interested nurses a brief but thorough course in facts about alcohol and alcoholism, thus clearing their minds of all hazy facts about this increasing social, economic and medical problem.

Plans for the Institutes were made last January by S. K. Proctor, Director of the NCARP, together with representatives from the three sponsoring state nursing organizations. Many sessions were held in which various needs for nurses interested in alcoholism were discussed. It was decided to hold the Institutes in Greenville for Eastern North Caro-

lina and in Asheville for Western North Carolina. The meetings would center around the fact that an alcoholic is a patient in need of the same loving care as one stricken with any mental or physical illness.

Over 65 nurses and visitors attended the Institute held in Greenville. The attendance in Asheville was most rewarding with over 95 nurses and visitors in the audience. All types of nursing professions were represented, including practical nurses, student nurses, Veterans Administration, general hospital and public health nurses.

Institutes Open

Both Institutes were held for one day, opening at 8:30 in the morning and continuing until 5:00 in the afternoon with a 2-hour break for lunch. The program titles for the two Institutes were: "Some Etiological Factors in Alcoholism", a showing and discussion of the film, "Alcoholism", a talk on "Medical Management of the Alcoholic", "Principles of Nursing Care" and the "Course and Treatment of Alcoholism." A member of Alcoholics Anonymous also presented a talk on that organization; following a short report on the NCARP was given.

Dr. John A. Ewing, Assistant Professor of Psychiatry at the University of North Carolina School of Medicine and Coordinator of Alcoholism Treatment and Research at North Carolina Memorial Hospital, opened the Greenville meeting with a discussion of the etiological factors in alcoholism. This same topic was delivered by Dr. Robert Dovenmuehle at the Asheville Institute.

During the past months, Dr. Ewing has drawn several conclusions from studying over 200 case histories of alcoholics which he has had under his care. Dr. Ewing found that there is a higher divorce rate among alcoholics than among the general population, with the onset of alcohol addiction occurring between the ages of 25 and 35. Dr. Ewing estimated that 70% to 80% of the alcoholics

studied could be classified under personality trait disturbances with the specific classification of passive-aggressive personality. He then explained that an alcoholic who is passive-aggressive is on the surface an agreeable, passive, unobtrusive person, but underneath has many aggressive tendencies which find outlets for assertion through excessive use of alcohol.

Dr. Ewing also reported that through studying these alcoholics, he finds very few socio-pathic personality disturbances; those characterized by a lack of concern for society's rules and morals or for the consequences of violating those rules. He did note, however, that most alcoholics seem to have difficulty in three areas of adjustment: dependency, hostility and sexuality.

Etiological Factors

At the Institute in Asheville held the following Friday, Dr. Robert H. Dovenmuehle, staff psychiatrist at Duke University School of Medicine and consulting Psychiatrist for the Keeley Institute in Greensboro, also discussed the etiological factors in alcoholism. Dr. Dovenmuehle explained to the group the characteristics of the alcoholic and how the use of alcohol affects his personality: his ethical sense and sense of judgment. As an example, he related the case of a hypothetical alcoholic in his 20's who drank only socially, but soon came to rely more and more on alcohol to relieve his underlying feelings of inferiority and low self-esteem. While under the influence of alcohol, this drinker's sense of judgment was lost and he performed acts which he would not have had he been sober.

Dr. Dovenmuehle discussed external factors prevalent in alcoholism: environmental conditions, occupational factors and cultural factors. He emphasized that the crises one meets in everyday living many times cannot be tolerated by certain personalities but that these crises are soothed through use of alcohol. In winding up his talk, Dr. Dovenmuehle said, "The turning point for the alcoholic is finding that he cannot live normally without alcohol. When he has to have alcohol to exist physically and mentally, then he has become addicted."

Completing the morning sessions of the two Institutes was Dr. Thomas T. Jones, general practitioner of Durham and staff member of Duke and Watts Hospitals. In speaking on the medical management of the alcoholic, Dr. Jones outlined a number of specific therapeutic measures which can be used very effectively in relieving the symptoms of acute alcoholism. He also stressed the need for doing something immediately for the acutely ill alcoholic patient. This immediate attention, he said, whether it be

Mr. Proctor talks with Dr. Robert Dovenmuehle, speaker at Asheville.

offering him a glass of water and an aspirin, a whiff of smelling salts, or a shot of vitamins, when given with an attitude of love and acceptance can do an alcoholic more good than all the latest techniques and drugs administered with an attitude of rejection and scorn.

Opening the afternoon session of both Institutes was a talk on principles of nursing care by Miss Millicent Griffith, R.N., Assistant Chief of Nursing Education at the Veterans Administration Hospital in Lyons, New Jersey. Miss Griffith's understanding and knowledge of alcoholism stems from a vast amount of experience in psychiatric nursing and an inherent interest in emotionally disturbed people.

In her talk Miss Griffith stressed the importance of good nursing care in the treatment of the alcoholic. She said, "Through the patient's hospitalization, a close personal relationship should be developed between the patient and the nurse. The nurse learns to know the patient and the patient derives confidence and helpfulness in realizing the nurse understands his particular problem. The nurse can either be a help or hindrance in a therapeutic situation, depending upon her attitude and approach to the patient."

Miss Griffith emphasized better understanding of the alcoholic as a human being on the part of the nurse. "There is a need to avoid creating within the patient antagonism and resentment, for although he recognizes the need for help, he cannot tolerate pressure. Do everything possible to build up his self-esteem. Give him praise and recognition when indicated. Show the patient that you are sincerely interested in helping him to get well and show him that you, too, play a valuable role on the team."

Both at Greenville and Asheville, a member of Alcoholics Anonymous

Left to right: Mr. Proctor, Miss Kneedler, Miss Dolan, Dr. Jones, Miss Griffith, Dr. Kelly and Miss Lytle at the Greenville Institute

spoke to the sessions on what being a member of AA has meant to him in terms of mental, as well as physical, sobriety and well-being. He contrasted his life before AA to that which he is now enjoying . . . without alcohol.

S. K. Proctor, Executive Director of the NCARP, outlined the progress the Program has made since its conception in 1949. "Through institutes, radio, TV, summer schools, seminars and newspapers, we hope to develop new resources, instigate new research methods, improve nursing and medical skills in the treatment of the alcoholic."

Immediately following Mr. Proctor's talk, the subject "Course and Treatment of Alcoholism" was delivered by Dr. Julian Lokey at Greenville. Dr. Desmond P. McNelis delivered a similar address at Asheville.

At the Greenville Institute, Dr. Lokey, staff physician at the North Carolina Alcoholic Treatment Center and State Hospital at Butner, opened his talk with a thorough description of symptoms of alcoholism. He spoke of the physical illnesses relating to alcoholism, such as cirrhosis of the liver and vitamin A deficiency, and outlined the treatment facilities for alcoholics available at the Butner Alcoholic Rehabilitation Center.

In his interpretation of the course and treatment of alcoholism at Asheville, Dr. Desmond McNelis, Clinical Director of the Butner Alcoholic Rehabilitation Center and State Hospital, defined an alcoholic as "a person who has lost control over the use of alcohol," although he said, "this definition may appear too simple for some."

The better part of Dr. McNelis' address dealt with the three stages of alcoholism: the pre-alcoholic symptoms, the early stages of alcoholism and the later stages. He sharply pointed out the warning signals and mentioned ways in which a purely social drinker may become an alcoholic. He explained that environmental conditions may make it very hard for the alcoholic to become or remain sober and that sometimes the alcoholic's spouse may unconsciously motivate his mate towards a drinking bender. Dr. McNelis praised the work of AA and in concluding his talk, emphasized that all factors leading to a patient's alcoholism must be taken into consideration when treating his illness.

Chairmen of the Greenville Institute were Mary Kneedler, R.N., Chief of Public Health Nursing Section for the N. C. Board of Health and Miss Margaret Dolan, R.N., President of the N. C. State Nurses' Association. For Asheville, Miss Dorothy Boone, R.N., Public Health Nursing Consultant for the N. C. Board of Health and Miss Mary E. Copeland, Western District Consultant for the State Board of Health Nursing Service acted as Chairmen.

Many interesting and helpful comments about the Institutes were turned in by the nurses at the end of the two sessions. Overall, they were most enthusiastic and seemed to have gained a good deal of knowledge about alcoholism which they did not have beforehand. One nurse says, "this has been of great value to me and certainly most educational. It has widened my perspective of the alcoholic greatly." Another wrote, "I feel this has been a day well spent. The program was well planned and informative. It has provided a better understanding of alcoholism."

From the appreciative attitude of those present at the Institutes and from the large number of attending nurses and guests, the success of the 1957 Nurses' Institutes on Alcoholism seemed conclusive enough to warrant continuing a program of this type in the future.

Here is a list of some of the personal qualities possessed by

THE MATURE PERSON

HE accepts criticism gratefully, being honestly glad for an opportunity to improve.

He does not indulge in self-pity. He has begun to feel the laws of compensation operating in all life.

He does not expect special consideration from anyone.

He controls his temper.

He meets emergencies with poise.

His feelings are not easily hurt.

He accepts the responsibility of his own acts.

He has outgrown the "all or nothing" stage. He recognizes that no person or situation is wholly good or bad, and he begins to appreciate the Golden Mean.

He is not impatient at reasonable delays. He has learned that he is not the arbiter of the universe and that he must often adjust himself to other people and their convenience.

He is a good loser. He can endure defeat and disappointment without whining or complaining.

He does not worry unduly about things he cannot help.

He is not given to boasting or "showing off" in socially unacceptable ways.

He is honestly glad when others enjoy success or good fortune. He has outgrown envy and jealousy.

He is open-minded enough to listen thoughtfully to the opinions of others. He does not become vigorously argumentative when his views are opposed.

He is not a chronic "fault-finder."

He plans things in advance rather than trusting to the inspiration of the moment. In terms of spiritual maturity:

He has faith in a Power greater than himself.

He feels himself an organic part of mankind as a whole, contributing his part to each group of which he is a member.

He obeys the spiritual essence of the Golden Rule: "Thou shalt love thy neighbor as thyself."

Life Without Liquor

(Continued from page 5)

with the alcoholic that they are considered. And, in the hope of helping the alcoholic, they repeat:

You are suffering from an illness. That illness can now be treated with reasonable hope of success in a great many instances. If you delay seeking treatment, you are taking a terrible risk.

Prolonged alcoholism can ruin your mind, destroy your health and cause violent and alarming reactions; debase your character and cause definite mental aberrations that may be either temporary or permanent. The result can include complete physical breakdowns and behavior involving serious crime.

Even if you sincerely desire to stop drinking, but attempt to do so without medical assistance, the chances are that you will be unable to continue to abstain. The underlying disorder that made you an alcoholic in the first place will probably drive you to drink again. In the commonsense re-education of the abnormal drinker, under psychiatric guidance, abstinence is a big step forward. But it is only the first step of a reorganization of yourself that will be the most important thing in your life.

Program Pointers

(Continued from page 4)

borough, Supervisor of Elementary Schools, Rutherford County, Rutherfordton. This aspect of our educational work is considered by us, our governing board and our friends as one of the more important of our contributions to the training of resource personnel and we sincerely hope we'll be in a position to continue the scholarship grants in the future. We encourage and invite persons interested to make applications for next summer's session early in 1958, when our applications and informational material have been prepared.

Another phase of our educational work has been the use of motion picture films on alcohol and alcoholism. In this we have had the cooperation and assistance of the Film Library of the N. C. State Board of Health. There are a number of motion picture films on alcohol and alcoholism that have been produced by various and sundry groups for specific purposes. However, in our opinion, only a few can be regarded as good teaching films, those free from extreme bias. Accordingly, we have purchased and supplied the State Board of Health Film Library with a few prints of these better films. We'd like to encourage the readers of INVENTORY to become familiar with them.

Alcohol and the Human Body, 15 min., 16 mm., sound, B & W

Alcoholism, 22 min., 16 mm., sound, B & W

I Am An Alcoholic, 19 min., 16 mm., sound, B & W

What About Drinking, 15 min., 16 mm., sound, B & W

In Time of Trouble, 14 min., 16 mm., sound, B & W

Domino, 26 min., 16 mm., sound, B & W

Alcohol and You, 36 min., film strip, silent, color

Citizens of North Carolina can acquire the above films on a free loan basis. For information about the loan or film content, write the Film Library of the North Carolina State Board of Health in Raleigh. Return postage is the only requirement.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

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JULY-AUGUST, 1957

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patient

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

VOLUME VII NUMBER 2

JULY-AUGUST, 1957

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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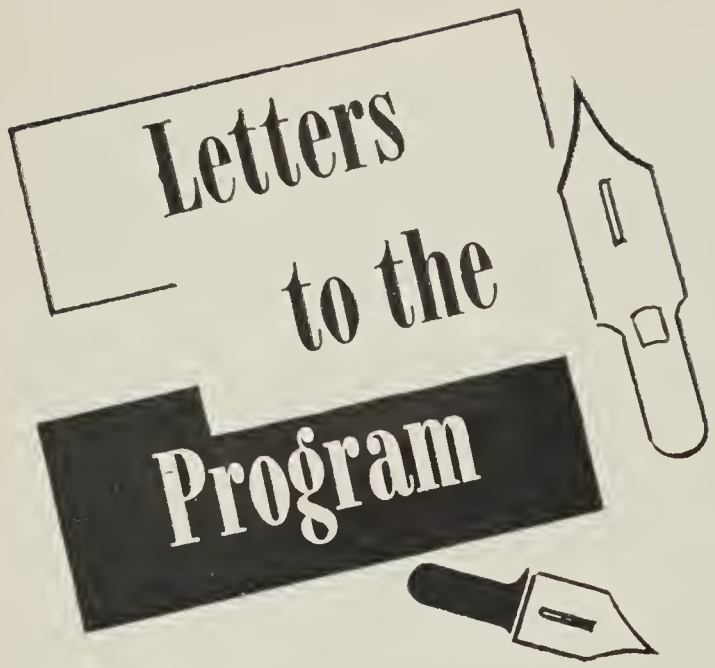

Praises Inventory

I cannot say enough in praise of *Inventory*. I have been receiving it since 1954 and wish to continue to receive it at my new address. Thanks for your great contribution in the field of alcoholism.

Priscilla Y. Sours
Corresponding Secretary
Peoria Committee on
Alcoholism
Peoria, Illinois

Minister Sends Thanks

Just a line to thank you for the two recent copies of *Inventory* which I received this week, and to commend you and your staff for an excellent piece of work. Your magazine contains the most helpful material on this question I've found anywhere. After seeing so much of the old approach of condemning the alcoholic, it is surely heartening to see the truly helpful approach of the rehabilitation program getting such wide circulation through your magazine.

Rev. Wilkes D. Macauley
Pastor, Kenly Presbyterian
Church
Kenly, N. C.

Fine Contribution

I am the grateful recipient of *Inventory* as it comes bi-monthly. I think the magazine makes an extraordinarily fine contribution to a difficult and prevalent problem.

Rev. Robert E. Cushman
Professor of Theology
Duke University Divinity
School
Durham, N. C.

Column Mention

Thank you for sending me a copy of "Alcoholics Are God's Children, Too." I am very much interested in this little booklet and would like to mention it in one of my columns.

Herbert Spaugh
The Everyday Counselor
Charlotte, N. C.

Caseworkers Meetings

Dear Mr. Proctor:

On behalf of the North Carolina Association of Case Workers I would like to take this opportunity to thank you and your staff for your contribution to our District meetings. We are aware of the extensive work it has taken to set up this program for us and we are deeply appreciative.

Mrs. Jo Mathews Cole
President
N. C. Association of Case
Workers

Helpful To Welfare Dept.

We find your bi-monthly journal on alcohol entitled *Inventory* very helpful and useful, since our department has been very much concerned and has been doing some work in this field for some time.

Hayes A. Richardson
Director of Welfare
Kansas City, Missouri

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

CALIFORNIA: According to a team of University of California researchers who conducted tests on students, alcoholics and mice, (1) persons who take both tranquilizers and alcohol become more intoxicated than those drinking alcohol alone, (2) there can be a delayed effect. A person using a tranquilizer could be "hit" later—maybe while driving a car. The study was conducted by Dr. Thomas M. Burbridge and Dr. Violette E. Sutherland at the University of California medical research center. Their findings were revealed in the first report of the State Alcoholic Rehabilitation Commission on research and treatment in California.

NEW YORK: The Onondaga Committee on Alcoholism found 75% of their inmates at the Onondaga Penitentiary were alcoholics. The Committee reported that 36% of the arrests in Syracuse, New York, during 1956 were for public intoxication.

NEWFOUNDLAND: People passing through Gander and spotting a young man wearing a little button with the number "12" on it will know that it's Bob P., a loner, who is always on the lookout for AA's. Wearing the "12" button is his way of making contact, yet preserving anonymity.

UNITED STATES: In this country alone, hangover cures are now a $50 million a year business, according to **Newsweek** magazine.

NEW YORK: The National Council on Alcoholism Publications Division now has available five copies of the kinescope film of the TV program on alcoholism produced by "Medical Horizons." The program was shown in March and emanated from Worcester, Massachusetts. The kinescopes are available on loan from the NCA. Also available through the NCA Publications Division is a new edition of the brochure, "What Every Worker Should Know About Alcoholism" put out by the AFL-CIO Community Services Committee.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

The 1957 Legislature has adjourned and members have returned to their homes. Appropriations have been made, departments and agencies have been notified of their budget allotments. A new biennium has begun.

I wish to thank all our many friends who wrote or contacted personally their legislators in support of our budget request. We received a number of letters from friends of the Program who had written to their legislators and/or to the Appropriations Committee. Their support was and still is appreciated.

While our appropriation was a disappointment, we did receive a gross increase of between $11,000 - $12,000 annually for the next two years. Our appropriation for the biennium just completed (July 1, 1955 - June 30, 1957) was $351,576. Our appropriation for the new biennium (July 1, 1957-June 30, 1959) is $375,149. This represents an increase for the two-year period of $23,573.

We are grateful for this budget increase, although it is hardly more than sufficient to maintain our present activities. It will not allow us to extend or increase our services as we had planned, however we feel that it represents a continuation of the confidence and respect the North Carolina General Assembly and the Administration has for the services and activities the ARP is attempting to provide.

We still have no funds available for research and we were allowed no increase in personnel.

In spite of the handicap of lack of finances and personnel under which we will have to continue to work, we of the ARP would like to pledge to the citizenry of our State and members of the General Assembly and Administration, our continued loyalty and devotion to the responsibilities which have been assigned us.

I should like to take this opportunity to express my gratitude publicly to my associates on the staff of the ARP. For our cause they have traveled many hundreds of miles over the State and spent numerous nights away from home. They have given generously of their time and talents in other ways as well. Each has been willing to put in long hours of overtime on those frequent occasions, sometimes on week-ends and in the evenings, when the demands on our time could not be satisfied during regular working hours. For their loyalty, for the long hours of lecture, clerical and office duties that each has so freely given, I say "thank you."

VOL. VII, No. 2 INVENTORY JULY-AUGUST, 1957

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Sympathy, kindness, objectivity—these are some qualities the nurse should possess if she would relieve the emotional pain of the alcoholic.

THE NURSE MEETS THE ALCOHOLIC

BY MILLICENT GRIFFITH, R.N.

IN a hospital setting, the nurse's first experience with the alcoholic is usually on the accident or medical ward. He is a patient who for the past several days has slept poorly or not at all. He has eaten little or not at all and is in a state of emotional turmoil. He may be suffering from delirium tremens or acute alcoholic hallucinosis, showing marked course tremors of the hand, tongue and lips; he is restless, extremely suggestible and delusional.

During this period, the same type of nursing is given the alcoholic as would be given any other patient with the same ailments on any medical or surgical ward. By that I mean, isolation from other patients and a sedative environment without any source of stimulation, such as noise and numbers of visitors. Articles of equipment should be removed. But I will not delve too deeply into the physical cares of the alcoholic patient, although it is important. I am concerned chiefly with the psychological needs of the alcoholic and the role the nurse plays in understanding and fulfilling these needs.

Pain Of Alcoholism

First of all, the alcoholic is in severe pain, emotional pain, which far exceeds any physical pain. The loss of job, loss of wife and family, loss of friends, are all a matter of pain; the very hangover means pain. It is the sort of pain which you see in a person overwhelmed by tension, apprehension, anxiety—overwhelmed by a sense of guilt and remorse. The knowledge that he is different in relation to other people has a tremendous effect on him.

These feelings are not with the

alcoholic all of the time, but they are ever present when he is sober. Yet this pain is constantly denied by the patient or is covered up. He cannot admit to this pain because he cannot stop drinking. It is pain which is the most significant tool to be used in therapy, for without pain there is no medication, thus no motivation and no therapy.

Yet despite the alcoholic's loss of friends, lack of money, home, job, with accumulated debts, rejection by wife and family, he resorts more and more to alcohol, knowing it provides only temporary relief and in turn increases the depth and complexity of his problem. He is caught in a vicious circular process.

"Hits Bottom"

In the life of every alcoholic there comes a time when he wishes to stop drinking. He may even say, "I hate alcohol for what it is doing to me. I hate myself for my stupidity and weakness. I hate it all." Yet he knows he is going to do it again. He is faced not only with a feeling of hopelessness, but there is always the struggle and desire within him to drink like a gentleman. But he loses control and finds he cannot take alcohol or leave it alone. It is only when the alcoholic has reached the so-called emotional bottom that he sees himself in his true prospective. It is often at this point that he seeks help.

The immediate withdrawal of alcohol is psychologically important to the alcoholic patient. It proves to him that there is no necessity for the use of alcohol in his case and this realization is the beginning of his re-education. The patient must break away from many of the ideas, attitudes and habits of his past life. He must learn that alcoholic beverages are not necessary in order to be cheerful and happy, and although they may help temporarily, in reality they only increase his difficulties. It is during this period that a close personal relationship should be developed and he, in turn, derives confidence and helpfulness in realizing that the nurse understands his particular problem.

The patient who comes to the hospital with an honest desire for help should be approached with sympathy and kindness. All ideas of punishment, fear of failure and attitudes of inferiority on the part of the alcoholic should be eliminated. One of the greatest problems a nurse may face is coping with the patient's uncooperativeness and trying to win his confidence. This is a challenge to any nurse and one she will need to meet if she is truly interested in caring for the alcoholic. The alcoholic patient cannot be hurried and to a

Millicent Griffith, R.N.

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This article is a condensation of a lecture Miss Griffith delivered at the recent North Carolina Nurses' Institutes on Alcoholism, held in Greenville and Asheville.

considerable degree the nurse must await the course of events. Only when the patient becomes cooperative can you work effectively with him.

Three Stages of Therapy

In a therapeutic situation there are three stages an alcoholic patient usually goes through before the physician can accomplish his goal. The first stage: the patient is aroused as to the existence of his problem. The second stage: the patient learns that his own method of solving his problem will not succeed. The third stage: the patient becomes cooperative and may be led with some chance of success from his former pattern of thinking. His thoughts are new and sober and he has a realization of his need for help.

It is only in the third stage that treatment proceeds with any degree of regularity or with much hope for accomplishment. The nurse can be a very important member of the therapeutic team in helping the physician and the alcoholic achieve this slow and painfully won cooperation. In order to be an effective member of the team, she needs to understand the role the doctor wishes her to assume. She needs to realize her importance in helping the doctor achieve his goal. She needs to have a thorough understanding of the alcoholic patient from a personal, interpersonal and social aspect if she wishes to help him. She also needs to understand herself and take an inventory of her own emotional reactions.

During the period when the patient is going through these three stages, he may express resentment and hostility. He may be anxious or experiencing feelings of guilt, thus reacting in a depressive manner. The nurse should act as a buffer to these feelings and recognize the mechanism of adjustment he is using, thereby providing constructive outlets for his hostility. The alcoholic patient is reluctant to accept defeat and may resort to ingenious ways and resources in thinking of methods of handling his difficulties. To argue with him is futile. All you need is patience and understanding.

Help Or Hindrance

The nurse can either be a help or a hindrance, depending upon her attitude and approach to the patient. There is a need to avoid creating within the patient antagonism and resentment, for although he recognizes the need for help, he cannot tolerate pressure. There is no place for the dogmatic approach. The atmosphere of the ward should be free from tension; the attitude of the nurse should be sympathetic, kind, non-judgmental and one of acceptance. She needs to understand the total needs of the patient and she must put forth every effort to build his self-esteem.

Many times the nurse is called upon to assume the role of a parent substitute, a mother, sister or aunt. It is essential that she learn to use a judicious mixture of kindness and firmness and not permit herself to become emotionally involved.

Frequently you may find a patient

(Continued on page 30)

Census Taker . . . How many in your family?
Woman . . . Five. Me, the old man, the kid, cow and cat.
Census Taker . . . And the politics of your family?
Woman . . . Mixed. I'm a Republican, the old man's a Democrat, the kid's wet, the cow's dry, and the cat's on the fence.


MD
L. TURNAGE

There was something about her eyes. And if you looked closely, you'd see behind that veiled wall that Anna Morris had a secret.

FANTASY

A VIGNETTE

BY CLAIRE CHENEY

IN the town of Greenwood, population 5,796, the mailman, drug store clerk or businessman on his way to work can set his watch by the time the public library opens its doors each morning. At five of eight o'clock, on the dot, Anna Morris, librarian and spinster, gets off the Peach Street bus and crosses over to the small and slightly unkempt building where she has spent the last fifteen years of her life. By eight o'clock, Miss Morris has her key in the lock and by five after eight, she has put up her umbrella which she always takes with her whether it rains or not, has hung up her cloth coat which the saleslady told her would be "serviceable" and is seated at her mahogany-veneered desk, waiting for her first customer.

They called her a prim and proper old maid. Her umbrella and briefcase were as familiar to them as the old, ill-fitting clothes she wore. But did they really know her?

No one in the town of Greenwood particularly notices Miss Morris. In fact, it has probably been years since anyone has ever really looked at her. She was born in the town, educated in the public schools and, upon failing to make a marriage, kept house for her widowed father until his death. She is now 40 years old and as much of a landmark in Greenwood as the bell tower which calls everyone to church on Sunday mornings. She is regarded as an astute, rather rigid old maid who is content to confine her world to books and the big family house in which she now lives alone. She has no close friends and makes no effort to cultivate any. She is a life member of the D.A.R., but aside from the library, that society affords her the only contact with people.

If anyone in Greenwood had ever looked at Anna Morris with any interest, they would have seen a tall, rather stockily-built, sharp-faced woman with black hair piled high on her head, severely tailored in an old tweed suit at least five years old with "comfortable" walking shoes on her large feet. In her hand would be her

umbrella and perhaps she would be carrying her brief case. Her face, which you would notice first would leave you with no lasting impression, unless you were particularly sharp of eye and saw that her mouth which she sometimes relaxed from its grim, straight, unpainted line was really quite pretty—almost vulnerable in its softness. And if her mouth caught your interest, you would then notice her eyes, close-set and determined, void of light and dull with lack of interest in things around them. Yet, there was something in those eyes and if you looked again closely, behind that veiled wall you'd see that Anna Morris, librarian, had a carefully guarded secret.

At four forty-five each day, after picking out suitable books for young minds, reprimanding those who bring in overdue books and cataloguing and sorting numerous cards, Anna Morris begins to tend to last minute duties before closing time. By four fifty, her desk is cleaned for the next morning and all books, magazines and chairs are straightened, and exactly at five o'clock, Anna Morris picks up her belongings and turns the key in the lock, to the average observer ending another day. She boards the bus to take her back to her empty house on Peach Street and sits in her seat with eyes straight ahead, her mouth forming a sort of smile. Her day's routine is regular as clockwork. From home to work, work to home. Mothers in Greenwood hold Anna Morris up to their daughters as an epitome of virtue: fathers teach their sons to regard her with respect and awe. She is thought of in the town as a good, if not dull, woman.

Upon arriving at her home each night, Anna Morris puts her umbrella and brief case in the hall closet, hangs up her cloth coat, looks around at the bare, meager antiques handed down to her from her great-grandmothers, sighs and then with a look of joyous anticipation quickening her face, hastens to her bedroom to her nightly ritual.

Down comes the black hair pinned tightly to her head until it flows around her shoulders. Next the coveted box which she keeps locked in her bureau drawer is fondled and then opened. From it comes a deep red lipstick which she liberally uses on her mouth. Perfume is touched behind her ears, a touch of mascara to her eyes, and then with a quick movement the tweed suit so becoming to Anna Morris, librarian, falls to the floor. In its place goes a lacy nylon robe wrapped loosely around her body, dainty pink slippers on her feet. Again she reaches into the box and takes out a cheap, flashy broach which she pins to her breast.

Now she is finished. She examines herself closely in the floor-length mirror on her bedroom door and tells herself, you're lovely, lovely. Oh what would they all say if they could see you now, she thinks, as she hugs herself, delighted with herself. Would the men look at me with their eyes so full of indifference now?

There are two other factors needed for Anna Morris to complete her picture. The victrola sits in the corner of her room; beside it is the worn record her mother and father had danced to. She could remember as a child watching them dance, while she, the outsider, stood and looked on. How she had hated them and the love they shared together, leaving none for her. And later, when her mother had died, the disgust and hatred of having to look after her senile father, washing for him, cleaning up his messes, cooking for him and never pleasing him, always hearing him say, "I wonder where Lucy is now?", always comparing her to her mother.

Anna Morris remembers and

laughs as she conjures up the looks of horror and shock on her parents' faces if they should see her as she stands in her robe and pink slippers, hair falling down her back, rouge painted on her face. A perfect hussy, they would say.

She winds the old-fashioned record player by hand and carefully puts the needle in the first groove of the record. It's a love song and the beauty of it fills Anna Morris with a sudden longing. One more thing, she thinks, and then I'll be ready. She goes to the kitchen, opens the refrigerator, takes out the ice tray and reaches in the cabinet for a glass. Slowly she places one ice cube in the glass and takes down a bottle—the magic potion which brings her her love and beauty. Filling the glass to the brim with the amber colored liquid, Anna gingerly holds the glass and bottle to her body and, keeping time to the music coming from her bedroom, dances a little step back to her room. Locking the door, she puts down the glass on the table beside her bed and lies down, her eyes closed, waiting.

Sip by sip she drains the glass, delighting in the soft, warm glow, stretching and moving her body in the rhythm of the music and drink. Another glass sip by sip is drained. The music plays on—the same love song over and over. To Anna Morris, the room becomes a palace, beautifully furnished in sleek woods and soft velvet. She is at a dance and everyone admires her lovely gown and graceful figure. The orchestra is playing for her and men circle around her, waiting to hold her in their arms. And there is John, the most handsome of all—John who loves her and to whom she returns his love.

Another drink. John is beside her now, standing next to her. "Dance with me, John," she says. She reaches out her arms to him as he takes her and waltzes her around the room. The orchestra plays faster and faster as she twirls frantically to keep pace. Everyone now disappears from the floor as she, the beautiful princess, dances with her sweet prince.

Again and again the glass is filled and then emptied. John and Anna, the handsome lovers, dancing, whispering, enjoying the magic of the evening. But it's late and the bottle is almost empty. John will leave soon and again Anna, the librarian, will be left alone. The inevitableness of the empty bottle and empty room causes Anna to drink faster, savoring each moment to the fullest.

Finally, spent, she falls to her bed. The music stops and the room is quiet. Her tweed suit lies huddled in a bundle on the floor. Next to it are her comfortable shoes, awaiting occupancy in a few hours. John is gone and all that remains for Anna is an uncontrollable desire to sleep.

And so each morning at five minutes of eight, Anna Morris, the town librarian, can be seen alighting from the Peach Street bus on her way to her world of books. Men and women passing by give her a slight nod and no more than a moment's thought. Her body seems to blend in with the sidewalks, the trees, and the automobiles. Strong dull Anna Morris—a person whose sternness is to be avoided by the children—a person whose prudence is heralded by their parents. Quietly Anna Morris goes about her work, smiling ever so often when she hears people say, "Poor Anna Morris. It must be lonely for her in that big old house night after night."

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If you are pained by an external thing, it is not this that disturbs you, but your own judgment about it.

Marcus Aurelius


BOURBO

Many alcoholic parents wonder, "Will my child inherit my desire for drink?" A leading scientist answers this disturbing question.

IS ALCOHOLISM INHERITED?

BY LEON GREENBERG, Ph.D
DIRECTOR
YALE LAB. OF APPLIED BIODYNAMICS

DO the children of alcoholics inherit a craving for alcohol? Does the use of alcohol damage the sperm or ovum and thus cause the progeny to deteriorate and degenerate? The first question is important because it concerns the stock of the human race. The second is important because it concerns the origin and development of alcoholism and therefore its control.

These are questions upon which there has probably been more discussion and, at the same time, more misunderstanding than upon any other. The broad importance of these problems both socially and personally is not difficult to see. Often the questions are asked: Does the use of alcohol by either or both parents bring about deficiencies and ill health in the children they bear? If such effects do occur, do they result from occasional intoxication, or only from alcohol addiction and chronic alcoholism? If deficiencies occur will they be passed on to succeeding generations? If one marries into a family in which there are alcoholics, is it likely that the children will have the craving from alcohol? Do alcoholics come from families of "bad" heredity? In matters which touch so deeply on both society and the individual every scientific fact must be carefully evaluated before statements are made.

Genetics

Before going into the facts that we have on this subject, in order that there will be some consistent understanding among us of terms that will be used, I will first deal briefly with some fundamental concepts and definitions of genetics.

Although it was recognized and known early in the recently gained scientific knowledge of genetics that acquired traits are not transmissible biologically, i. e., by heredity, this fact has not, even to this day, be-

come part of public knowledge. From scientific data it is now evident that the similarities between parents and offspring may be of two kinds:

(1) Those which result from direct biological transmission. These traits are called "inherited characteristics."

(2) Those which can be accounted for by imitation, by exposure to example, or by the same kind of environmental influence acting on the parent or child. These traits are called "acquired characteristics."

A distinction between the two is in some instances difficult to perceive because a particular behavior trait which is in reality an acquired trait, may appear on the surface to be hereditary. But actually it is the result of environmental influence on an hereditary disposition—or inherited characteristics which facilitate a particular acquired behavior.

Let me try to illustrate this last point by simple example. Tom was six feet and four inches in height and an outstanding basketball player at college. He became famous for his skill at this game. Twenty-five years later his son, Tom Junior, also over six feet tall became a basketball player of note. Did Tom Junior inherit basketball playing from his father? Was playing basketball in the genes? Of course not. He learned it—he imitated his father—it was *acquired* behavior. He did inherit biologically the physical stature that disposed and facilitated his excellence in the game.

Environment

With regard to acquired characteristics resulting from environmental influences, one other matter requires clarification. Environment includes not only the world into which the child is born, but also his sojourn in the uterus from conception to birth. in the later environment—in the uterus—he is subject to diseases, to malnutrition, to unusual physical stresses and disturbances. The effects of these on characteristics of the child are referred to as congenital characteristics. Not all the characteristics with which the child enters this world are inherited. Direct transmission, as I have pointed out before, occurs only through the genes. Only what is present in the egg and what is added to it by the sperm plasm at the time of fertilization—at the time of conception—constitute hereditary transmission. Once fertilized, the egg has started on its development. It cannot receive any more traits from the parents, but it can be influenced by its environment, not only after birth but in the uterus, in its earliest stages. If this intra-uterine environment is defective, then the developing embryo will be subject to modifications —to congenital changes. Such modifications are not inherited traits. They do not come from the genes of the father or mother, but are brought about by intra-uterine environment. With a more consistent and perhaps clearer definition of these basic concepts of genetics, let us now turn to the question of alcohol and heredity.

Three Classifications

This is a question to which most study has been given, and may be broadly classified in the following three groups of problems:

(1) Does the chronic or acute use of alcohol in sufficient quantities cause such damage to the germ cells, that is, to the eggs of the mother or the sperm of the father, as to manifest itself in defects of the offspring?

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Many slips can be charged off to heredity—especially in those who have been mothered by Miss Information.

From Southern California EYEOPENERS

(2) Does parental alcoholism bring about a true genetic change in the offspring?

(3) Is there an hereditary liability involved in alcoholism, i. e.—

(a) Is alcohol addiction directly inherited?

(b) Is a constitution inherited which is more liable to resort to intoxication?

The first problem relates to the direct effects of alcohol on the germ plasm—the egg of the mother or the sperm of the father. It is a basic biological fact that the germ cells are exceedingly well protected in the body, to the extent that the body will die before injury to the germ cells occurs. The only exceptions to this are rare disturbances which specifically attack the tissues of reproduction. Moreover, if they are injured, germ cells usually die or cease to develop, instead of becoming abnormal; only sterility then results. The problem then is: does alcohol injure the germ cells to just that slight extent which does not cause destruction but which does cause abnormality? In considering this problem, one fact must continually be borne in mind. What we are considering here is injury to the human egg or sperm so as to result in the conception of children that are abnormal.

External Influences

Injuries which occur to the developing child after conception and injuries which occur to the child after birth are not part of this consideration. No one will deny that a mother who is frequently drunk, whose health is actually injured by excessive use of alcohol, is a poor mother to bear and raise a child. Equally, no one will deny that a father who is a chronic alcoholic is a poor father and makes a home unsuitable for a child. But these facts do not concern damage to germ plasm from which the child was conceived—any more than do poverty, illness, neglect and brutality. They belong to what is called environment —the surroundings of the child. Unfortunately this important distinction is not always made and many people erroneously speak of heredity when they really mean the home life of the child.

Germ Cells Not Affected

Germ cells do not have nerves; they do not become intoxicated, and they are injured by alcohol only when it is present in concentrations far higher than that which causes death of the individual. No acceptable evidence has ever been offered to show that acute alcoholic intoxication has any effect whatsoever on the human germ, or is the cause of any abnormality in the child. All facts point to the conclusion that the germ cells are far too resistant to be injured by the concentrations of alcohol in the blood which occur in acute intoxication.

The resistance of the germ cell in the body to chemical substances and the toxins of disease is well known—and alcohol does not form an exception. Ether used for anesthesia has nearly the same effect on the body as alcohol—both are anesthetics although alcohol is weaker. No one would believe that anesthesia given for a surgical operation—even though the intoxication was much more severe than that of alcohol—would injure the germ cells and cause defective children. And even though conception does not occur under such anesthesia, the fact remains that the male and female germ cells are present in the body for many days during their formation and storage; so that any conception occurring within one or even several weeks after anesthesia would be with germ cells

exposed to the anesthetic. The anesthetic has no effect on the heredity of the child—and neither does alcohol.

It must be borne in mind that we are dealing only with heredity—the germ cell—and not with the influence of the poor nutrition of an alcoholic mother on her unborn child, or the influence of alcoholic parents on the environment of the child. While this distinction may seem to be of no practical importance, it is in effect most significant. If the belief is held that the ill effects are due to germ damage, the prevention seems most difficult if not hopeless; for hereditary weakness cannot be remedied after the child is born. When, however, it is realized that the effect is not due to a fundamental weakness of the child, but instead to home and social conditions, its remedy is no longer too difficult or impossible.

Increased Mortality

It has been proven that mortality of children in alcoholic families is much higher than in temperate families, in fact, about twice as high. This fact has often been taken as certain proof of germ damage of alcohol; it has been presumed that because of germ damage the children were weakened and because of their weakness had less chance to survive. There is no scientific evidence of this. But there is ample evidence that children of alcoholic parents have less chance to survive, not because of defects in the germ, but because of the environment into which they were born, because of the neglect they sustain from the irresponsibilities and irregular habits of their parents.

What I have pointed out regarding alcoholic parents and infant mortality applies to alcohol and the occurrence of disease in children. There is no evidence whatsoever that diseases in children are due to weakness inherited by the child from the alcoholism of the parents. It is due to lack of prenatal care and neglect of the child after birth because of the excessive drinking habits of the parents.

We come finally to the question of the hereditary liability involved in alcoholism, that is, is alcohol addiction itself biologically transmitted, or is a constitution inherited which is more liable to resort to intoxication? Interest in these questions has been extraordinarily great. Opinions and statements on them have been profuse. Why? Because the etiology—the causes—of alcoholism are not simple and have often been baffling. It would, therefore, be most convenient to have a simple explanation—a neat package—labeled heredity. This easy explanation has led many a writer on alcoholism simply to disregard accumulating scientific evidence—if he has ever looked at it at all—and to declare that heredity is the answer.

What is the evidence that a craving for alcohol or a craving for intoxication is transmitted biologically? There are some surmises as to the hereditary transmission of so-called "tolerance" to alcohol. No evidence exists on this point, the definition of "tolerance" is not clear, and any possible relationship between "tolerance" and alcoholism is even more confused and uncertain. There is some experimental evidence on the heredity of alcohol taste—thresholds or preferences, but it is questionable whether this has any relevance to our subject since alcoholics rarely drink because they like the taste of alcohol—in fact, many dislike the taste.

Other than this, there is no evidence of biological transmission of addiction. The distinction between

biological and social transmission, the discovery that acquired traits are not transmissible, that biological traits can be modified through the environment, and that in many instances not a disease or trait is transmitted, but rather a disposition, a readiness to acquire such a disease or trait,—all point, in fact, to the opposite. Abnormal drinking and the craving for alcohol are acquired traits and acquired traits are not inherited.

If we phrase our question in another way, which is perhaps closer to what we really want to know, then the answer would be different. Are the children of alcoholics more apt to become alcoholics themselves than are the children of temperate parents? The answer to this is "yes." There are three reasons why the children of alcoholics tend to become alcoholics, and none of these is due to alteration of heredity caused by alcohol itself. The reasons are:

(1) The poor home environment of the alcoholic family, the neglect of the children and lack of parental control are fertile grounds for the development of all kinds of excesses.

(2) The children find in their parents an example of excessive drinking and tend to follow this example.

(3) A percentage of excessive drinkers come from families in which mental disorders and abnormalities of personality are inherited traits. Individuals with such inherited traits are often much less able to resist intemperance to many things including alcohol than are normal individuals, and so become excessive and abnormal drinkers. What they may transmit biologically to their offspring is their inherited mental abnormalities, not alcoholism.

The fact that these factors do exist among alcoholics, that they may have been inherited from their ancestors and may be transmitted biologically to their children, does not justify the implications of hopelessness, that the children of alcoholics, by fate, must be alcoholics. Quite to the contrary, the knowledge that alcohol addiction is not a genetic trait can give to the afflicted excessive drinker the needed conviction that alcohol is not for him a biological "must."

To society, the knowledge that excessive drinking is an acquired behavior that flourishes in the presence of certain mental and personality liabilities, provides a better orientation in treatment and rehabilitation. In view of this knowledge, since alcoholism is transmitted only socially, rehabilitation of the alcoholic is also a step in prevention. When he is rehabilitated, he rehabilitates his home and no longer risks his excessive drinking as a bad example to his children who may already have an increased liability to alcoholism.

Summing Up

My discussion of alcoholism and heredity may be summed up thus:

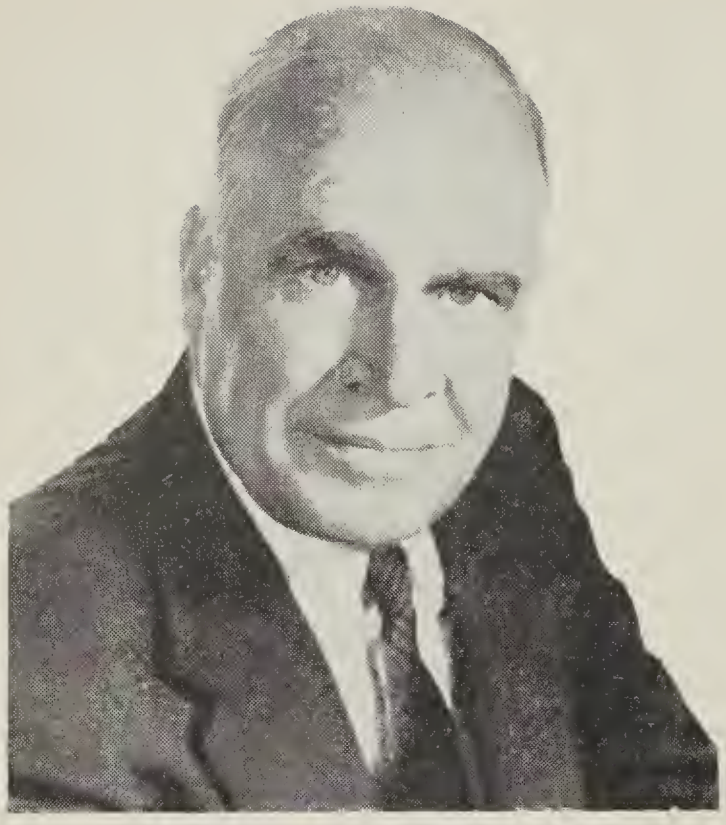
(1) The use of alcohol does not injure the human germ and cause abnormalities in heredity.

(2) The greater incidence of disease and mortality among children whose parents are abnormal drinkers, as compared with those whose parents are temperate, is not due to germ damage. It is due to the low standards of living and neglect in the homes of excessive drinkers.

(3) Excessive users of alcohol frequently come from families of poor hereditary stock.

(4) The defects they inherit are not alcoholism, nor are they caused by alcohol, but they may predispose to alcoholism.

(5) A knowledge of these facts is important to a better understanding of the causes, treatment and prevention of alcoholism.



LUTHER H. HODGES
GOVERNOR OF NORTH CAROLINA

We are proud to reprint in Inventory this address by Governor Luther H. Hodges, delivered to the 10th annual state convention of Alcoholics Anonymous. This convention was held in Greensboro May 25-26. The Governor's speech was a fitting climax to the three days of workshops, addresses and social affairs for the 1,000 AA members attending.

GOVERNOR HODGES

LADIES and Gentlemen of Alcoholics Anonymous:

Thank you for inviting me here today. It is good of you to allow a "civilian" to have a part in your annual convention.

I am deeply concerned with the problems of alcoholism—as every North Carolinian should be—and I am proud of what you men and women are doing to meet the problem for the good of your souls, the love of your brother, and the glory of God as your understand him. I am impressed with your practical sincerity.

Friends in AA have told me that yours is a selfish program; and that you help others because, in so doing, you help yourself. Well, if that's the way you want it, I won't argue with you. But, if a member of AA, doing what you call "twelfth-step work" is selfish, then so was the Good Samaritan—and that's not the way I interpret the story.

But be all that as it may—be you selfish, as you contend; selfless, as I believe—to you and to Alcoholics Anonymous, North Carolina owes a great debt of gratitude. And because your opportunities for greater service are almost unlimited, I believe the State's debt to Alcoholics Anonymous will increase in the years to come.

Let me, as an outsider, point out North Carolina's problem of alcoholism, as I see it.

Experts have estimated that there are about 4,500,000 victims of alcoholism in America. State authorities estimate that we have some 60,000 alcoholics within the borders of North Carolina. And, I am told that AA's 118 North Carolina groups have a total membership of 2,316. This from a small beginning 15 years ago when a medical doctor and an engineer started a group in Shelby and a lawyer started a group in Northhampton County. In other words, my

"I am deeply concerned with the problems of alcoholism—as every North Carolinian should be—and I am proud of what you men and women are doing to meet the problem for the good of your souls, the love of your brother, and the glory of God as you understand Him."

SPEAKS TO ALCOHOLICS ANONYMOUS

friends, your field for growth and more service is great indeed. I understand that your membership in the last 5 years has more than doubled. It is my belief as well as hope that the growth of AA during the *next* 5 years will exceed even your fondest dreams.

It has been estimated by the experts on the subject of alcoholism that the lives of at least 20 people are affected in some way by the illness of a single alcoholic. These 20 people may be members of his family, or fellow workers, or just friends. But it is not hard to believe that an average of 20 people suffer to some extent by every alcoholic illness. And if that is so, we can readily see that almost one-third of the population of North Carolina already is affected by this illness, which in your case has been so wonderfully arrested.

All of you know, better than I, the untold suffering which alcoholism brings to the individual alcoholic, and to members of his family. That, of course, is the worst phase of the illness. But also well worth the public's consideration is the cost of alcoholism in dollars and cents to business, to industry and to government.

Loss To Industry

The actual figure of the loss to industry cannot be accurately measured, but industrial statisticians say that in this country the annual cost of alcoholism to industry alone exceeds a billion dollars. Loss of time, increase in accidents and injuries to the alcoholic and his co-workers, increase in waste, increase in disability payments, and the resulting increase in the cost of compensation insurance all go into that estimated billion dollars. These are the tangible costs. But consider also the intangible costs —which can't be measured. I refer to the decreased efficiency of the alco-

(Continued on page 22)

A non-alcoholic comments on her first association with Alcoholics Anonymous

A "CIVILIAN'S" VIEW OF THE A. A. CONVENTION

THE lobby in the King Cotton Hotel in Greensboro was buzzing with activity last May as I met for the first time members of Alcoholics Anonymous. This was the occasion of the North Carolina AA Convention, an annual event at which hundreds of AA's all over the state and adjoining states gather together to seek inspiration and encouragement from others to take back to their AA friends at home. Mr. S. K. Proctor, Executive Director of the NCARP, Dr. Kelly, Education Director, George Adams and I were present at the Convention upon the invitation of AA.

I have been with the NCARP only since February. Every minute of that time has been spent at the typewriter or at the books, learning about alcoholism, writing about alcoholism. I more than welcomed the opportunity to attend the 1957 AA Convention because I wanted the experience first-hand of meeting recovered alcoholics. How did they obtain sobriety? What keeps them sober? How do they feel about never taking another drink? I had all these answers from many, many books, but there is nothing like human contact, no substitute for learning from other human beings.

My first impression when I entered the lobby of the King Cotton was one of amazement. There were so many people, or so it seemed to me, and each was smiling and laughing. Here and there were groups of four and five AA's gathered around in circles, men and women shaking hands and greeting others as they walked in behind us. "Hey, Bill, have you met Al?" "Glad to see you, Nancy. Where've you been keeping yourself?" Everyone so glad to see the other; strangers meeting strangers and greeting them like old friends. The atmosphere was one of a tightly-

knit club, except that it welcomed with enthusiasm each new member.

As we checked our reservations at the desk, I looked closely at the people standing next to me. Were they AA's, visitors, professional people? I couldn't be sure, for, you see, an AA looks just like anyone else you might meet. He wears no badge of his alcoholism, his past heartaches and losses; no physical marks tell you he is an alcoholic. AA's say, however, that one sure way to tell an AA from a "civilian" is that an AA *always* has a big smile on his face while the non-AA might not.

So, here I was, a "civilian", an outsider, attending an AA Convention. My hesitancy at entering into their group, my fear of intruding, my uneasiness at being classified a "professional" were sharply pointed as I stood in the midst of these people who had been through so much. I felt as I did in my college days at wanting to join a sorority. "Would I get the bid?"

I found that weekend that my fears were ungrounded. At the formal meetings held in the hotel's big dance hall and then at the high school auditorium when the crowd grew too large, I heard members of AA speak of their experiences with alcohol and how AA had helped them achieve and maintain sobriety. Each night the hall was packed; people stood in the aisles and those lucky enough to get a seat were jammed together like sardines. Yet I could practically feel the empathy and acceptance each AA felt for the other as I sat and listened to one speaker after another. Here were people who had experienced similar emotions, had known similar sorrows, frustrations, rebellion, sickness. They told about their past without embarrassment. They understood each other and offered their help. So different from any meeting I had ever attended where each person was too concerned with his own problems to ever give a hoot about the other person.

These members of AA, all twelve or thirteen hundred of them, were deeply interested in their friends' struggles with alcohol. They were working together for sobriety and happiness. They had learned they could not win their battle alone; many of them had tried and failed. They had learned through sharing themselves and their experiences with others that perhaps their difficulties had not been so bad after all, not when you consider what Joe went through, and by listening to what others had to say, they helped themselves in maintaining sobriety. They seemed to find emotional catharsis in discussing and re-discussing their past alcoholic life—as if by keeping the memory alive of what they had once been helped them to achieve what they wanted to be.

All my questions about AA were answered that weekend and I learned something even more basic: how much we all can learn from AA; how good it would be if we "civilians" followed the principles behind the AA way of life—

Claire Cheney

God grant me the serenity
to accept the things I cannot change,
the courage to change the things I can
and the wisdom to know the difference.

(Continued from page 19)

holic who would be an asset rather than a liability to his company except for his illness. I refer to his impaired judgment, to his slower reactions, and to his loss of ambition and morale. When we consider all these things it becomes apparent that the billion-dollar figure is probably far too low.

It is estimated that the problem drinker loses an average of 22 working days per year, which is twice that of the normal drinker. But the time lost does not stop there. One of our larger North Carolina concerns which employs a great number of women does not have much of an absentee problem from alcoholism among its employees. But it does have a very real absentee problem due to the excessive drinking by the husband of the working wife. And though there are no figures to bear out the statement, there is every reason to believe that alcoholism of the parents has injured the school record of many a child, thereby taking the waste of today into the future efficiency of our people.

Alcoholism and Crime

Colonel William F. Bailey, our State Director of Prisons, informs me that at least one-third of the inmates of the State Prison System were sentenced as a result of crimes associated with drunkenness. That is just another reason why all good North Carolinians should be concerned with the problem. Heaven only knows what is the cost of alcoholism to the taxpayer, but it is my belief that it is even greater than the cost of alcoholism to industry. Alcoholism has played its part in increasing the welfare and relief roles, in filling our institutions, and in lowering our per capita income.

There is not a man, woman or child in the State who is not affected, directly or indirectly, by this illness.

There is much talk on all sides about liquor and what to do about it by law. You know far better than I that it is mainly an educational problem affecting the individual, the community, the state and the nation.

People like yourselves can help a lot in this educational phase, but you have an opportunity to accomplish probably more by dealing with those who get the "disease." In the task of getting accurate information to the public, your individual support of State and local agencies engaged in public education about alcohol and alcoholism can mean the difference in their success or failure.

There is nothing new about the problem of alcoholism, but it is only recently that real progress has been made towards its solution. And for that progress Alcoholics Anonymous is in large measure responsible.

AA Groundwork Laid

Back in 1934, when a New York stockbroker and an Akron physician founded your beloved fellowship, almost no one thought of alcoholism as a disease. The alcoholic was generally believed to be a weak-willed, irresponsible individual for whom little could be done. But Bill and Dr. Bob, struggling first with themselves and then with other alcoholics, laid the groundwork for our modern concept of alcoholism as an illness. As more and more alcoholics regained sobriety through Bill's and Dr. Bob's simple recovery program, the world was furnished with dramatic proof that alcoholics, in large number, could recover. This was indeed a revolutionary idea. It brought the dawn of a new hope to persons already affected by the disease. And more than that, it stimulated the medical and scientific professions and public health agencies in this country to study the problem and join

AA in taking steps to combat alcoholism.

Out of the efforts of that group of pioneer AA's has grown a fellowship of 120,000 members, divided into some 4,100 local groups. Out of their dramatic demonstration that alcoholism can be arrested, has grown a whole network of state, community and private organizations devoted to the treatment and prevention of alcoholism.

So the effect of AA has not been limited to its membership alone. As a result of your leadership, state governments have come to share your concern with the problem of alcoholism. We are proud that North Carolina was among the first states to join you in this work. The State of North Carolina, through its General Assembly of 1949, appropriated funds to the Hospitals Board of Control, making possible what is now the North Carolina Alcoholic Rehabilitation Program. The Program finances a Treatment Center at Butner, North Carolina, operated by the staff of the Butner State Hospital. It further attempts to provide out-patient assistance to alcoholics and their families through clinic services in some of our State's communities.

NCARP

Equally important in the Program's work is their interest in the prevention of alcoholism through education and research. Skilled professionals in the ARP direct an educational program which has generally been recognized as the leading one of its kind in the United States. Finally, this State Program is vitally concerned with stimulating and promoting local community resources aimed at the treatment and prevention of alcoholism. It exists as a State Agency staffed and equipped to provide the leadership, guidance and consultation service to local communities, local agencies and institutions to help them develop or improve their own resources in combating this serious medical and social problem.

Our own State Prison System has turned to AA for advice and counsel. The Prisons budget proposed for 1957-59 includes a request for an Alcoholism Counselor at $4656 per year. It would be the job of this person to organize groups of Alcoholics Anonymous in our various prison units and to secure the cooperation of outside groups of Alcoholics Anonymous in keeping these prison groups active and effective.

What is planned, if this position is approved, is the employment of a man who has been an alcoholic and is active in AA work, a man who can speak the language of the alcoholic, a man who will be trusted and respected by the alcoholic behind the walls, as well as the arrested alcoholic in AA.

I would not attempt to estimate how many of the 6,107 persons committed to our prisons system during 1956-57 for offenses related to drunkenness are alcoholics—by that I mean compulsive drinkers. But the percentage may be high. I do know that the only way many of these men and women will ever be prevented from returning time and time again to prison cells is for their disease of alcoholism to be arrested.

AA In Prison System

I am proud to see that AA has already made a start in our Prison System. The record of the Central Prison Group of AA has been good. Fairly recently, a second group was organized at Women's Prison. Mrs. McCubbin, the Superintendent there, has long been aware of the sizeable number of alcoholics among her Prison population. Wanting to do something to help them, she first

invited members of our State Program staff to conduct a series of educational meetings with interested prisoners. These continued over a six-month period. At the end of this time, the prisoners decided, on their own, that they would like to organize an AA group. For its success and for that of the Central Prison Group, much credit is due those dedicated members of AA from Raleigh and nearby towns who each week come to our Prisons to work with these groups of prisoners. It is with admiration and gratitude I report to you that some of our best citizens have been engaged in this important work.

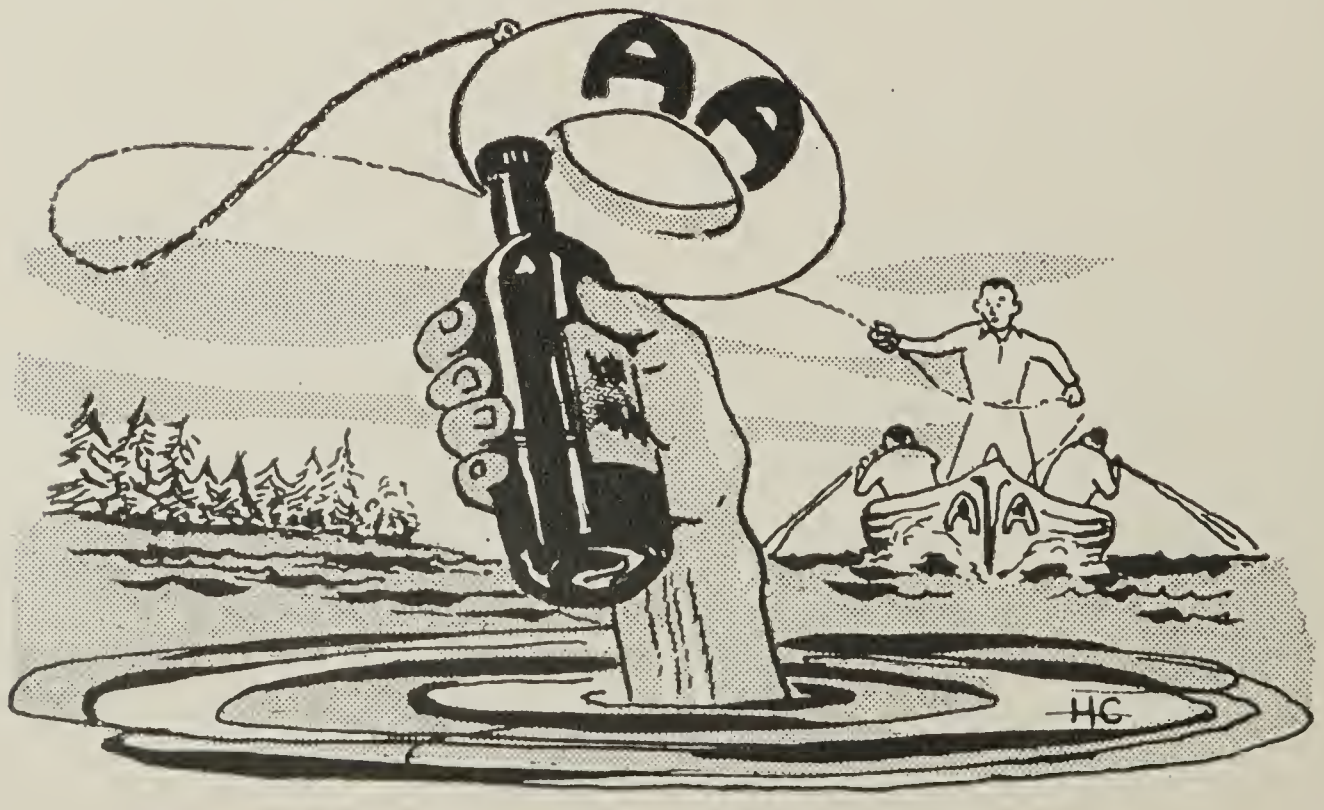
Your fine examples of recovery from alcoholism have helped to awaken local communities in our State to their responsibilities in meeting this problem. It is a source of pride for me to note that a number of communities in our State have already organized local citizens committees on alcoholism. The committee here in Greensboro is a good example of what can be done at the community level. I understand the Greensboro Program owes its existence in a great measure to the devotion and hard work of members of AA. AA's are active, too, in the other citizens committees in the State.

It is likely that the various State ABC Boards will be looking to AA and to our State Program for more help with the job of alcohol education. By the act of the Legislature now in session, it is possible that five percent of the profits of all ABC sales soon will be used for educating the public concerning the effects of alcohol and the illness of alcoholism.

The fact is that the seeds you have sown are now growing all over North Carolina. And please believe me when I tell you, my friends, that your State is grateful.

What you have done for yourselves is wonderful; and what you are doing for your fellow sufferers and for all mankind, is even greater.

And so, Ladies and Gentlemen of Alcoholics Anonymous, I salute you —the only set of "selfish" Samaritans it has ever been my good fortune to know.



THE TENSION YEARS

BY GEORGE ADAMS

Most young adults take the adjustments of this age period right in stride. But some are tipped off balance and into alcoholism.

THE fortieth birthday is supposed to signal the onset of one of life's dangerous ages, when the eyes and affections of hitherto devoted spouses may wander to greener pastures. But there is also another "dangerous" age—beginning at about age 25 and continuing through the mid-thirties. And this one isn't concerned with marital meanderings.

What the heck is dangerous about being a young adult, you ask? The answer: You're more susceptible to the onset of alcoholism at this age than at any other period of life.

Now, there is a paradox for you. Why is it that young people at the peak of their mental and physical capacities for enjoying life should be most vulnerable to this illness which is a symptom of unhappiness and maladjustment?

Complex Pattern

To find the answer we will take a closer look at the kinds of stresses and strains which are part and parcel of the young adult pattern of life. We should try to understand, too, the emotional resources, or lack of them,

of the persons within this age group who fall victim to uncontrolled drinking.

The young adult is subjected to a rapid fire series of adjustments, a far cry from the protection provided by the parental home. First, there's marriage, the breaking of parental ties and the establishment of a new home. Sexual expression must mature to allow for building a warm emotional as well as physical relationship with an individual of the opposite sex. Next, children may come along and the lives of young marrieds again change drastically. The young person of this age is usually setting out toward the vocational goals which he has already established. Financial independence from the parental home and financial responsibility for a new home must be set up.

Each of these adjustment steps is a potential source of stress and anxiety for a young man or woman. The great majority are stable enough to take the steps in stride, maintaining at least a measure of their equanimity. But others, poorly prepared emotionally, are apt to be tipped off balance. Some inevitably find in drinking a convenient, socially acceptable means of escaping the pressing responsibilities and demands of the young adult years.

That's what happened to Ralph H., who is an alcoholic at the age of thirty-two.

"Exemplary" Child

Ralph was the son of a domineering, overprotective mother. His father was a busy physician who was seldom home and had little to do with his son. Ralph was described as an "exemplary" child. He grew up accustomed to having his mother make all of his decisions for him, always following her advice. Ralph made a good record in high school and attended college in his home town, while living at home. After graduation he took employment in a trainee position with a large company. Shortly after beginning work, he married his childhood sweetheart on whom his mother had already stamped her approval. Ralph's wife, an attractive girl, had been overindulged by her well-to-do parents and was accustomed to having all the best of everything. She soon began to demand of Ralph all the attentions she had received from her parents. She expressed constant dissatisfaction with Ralph's limited salary, urging him to land a better position or quit the company. Ralph, accustomed to thinking of marriage as an idyllic state, panicked when he felt the full impact of its many responsibilities.

Drinking Increases

Up to this time, he had been a social drinker. But now, his drinking became more frequent. He usually stopped at the corner bar for a few "quick ones" before going home after work. He found that those drinks helped to relieve his painful feelings of failure when he arrived home to face the barbs of his wife's complaints. At her urging, Ralph assumed financial obligations clearly out of his reach. He bought a house and a deluxe new car. The budget groaned and creaked under the load. When he finally had to give up both car and home, Ralph's feelings of inadequacy and failure reached a crescendo and his drinking, already excessive, blossomed out of control.

Why did Ralph become an alcoholic? It's simple, you say? He had a nagging wife. No wonder he drank! But is it that simple?

Marital conflict certainly seems to be one factor which triggered Ralph's problem drinking. But don't put all the blame on the strife-filled marriage. Single factor explanations of

alcoholism are over-simplified, never accurate. More important, are the personality traits which Ralph (and his wife) brought to the marriage. His overprotective mother (and absentee father) had, without realizing it, been Ralph's undoing. Mom had never given Ralph a chance to assume any responsibilities, a very satisfactory situation for a child as long as Mother is always around, but hardly good preparation for meeting the responsibilities of marriage and adult living. She had unwittingly shaped him into an overdependent adult male completely incapable of coping with the demands of the spoiled child he married. The pressures of young adulthood have torn him loose from his flimsy emotional moorings. No longer able to turn to his mother for help ("grown men don't run to Mama!"), Ralph seeks the solace of the bottle for relief from his distressing feelings of inadequacy and failure.

Co-Culprits

Marital conflict, as in the case of Ralph H., linked with the personality trait of overdependency appear as co-culprits in a surprisingly large number of cases of young adult alcoholism. But there are other negative personality quirks which combine with everyday problems to produce uncontrolled drinkers. Here's a capsule case history of Jim D. which shows how repressed rage resulting in occupational failure helped fan the flames of this young married man's addiction to alcohol.

Jim was the oldest child of a marriage which was raw with harshness and conflict. Jim's father was a woodshed disciplinarian, often beating Jim for even the slightest breach of discipline and subjecting his son to a constant torrent of criticism for his failures. The boy's mother, a cold, indifferent woman, showed little affection toward her family. Jim finished vocational high school, then went to work at 18 as a skilled worker in a tool and die plant. He was married two years later to a quiet, gentle girl and his marriage has apparently been a happy one. Jim is now 28 and during the ten year interval he has held and lost a dozen different jobs.

Jim says that in each job he liked his boss and believed himself popular with his superiors and co-workers. Of his own job performance he says, "I made a few mistakes, but you don't can a man for that." He admits, however, that he made more mistakes when his boss or supervisor was nearby or looking on. Jim's record shows that he was fired from a number of jobs because of personal negligence, inefficiency and a series of small but costly accidents which were traced to him. Fired outright from the first few jobs he held, he then started beating his company to the punch by quitting in a huff over some minor dissatisfaction before they had a chance to fire him. As Jim's job failures mounted, so did his drinking, although he never actually lost a job because of it. Each lost job, though, signaled another drinking spree and periods of unemployment stretched from weeks into months. Though only 28, he had unquestionably passed the borderline into alcoholism.

Jim's worries over repeated job failures undoubtedly added to the normal stresses which go along with being 28, and heightened his susceptibility to alcoholism. But again, as in Ralph's case, the causes of his job failures—and ultimately his problem drinking lie in the deeper underpinnings of Jim's personality. Bottled up within himself a great cauldron of anger and hostility boiled. Who was he angry with? Originally his

(Continued on page 31)

ALCO-FAX

1) Alcohol is a stimulant, which produces the same effect on the body as caffeine.

True ☐ False ☐

2) Excessive alcohol taken into the body over long periods of time will eventually cause deterioration of the brain cells.

True ☐ False ☐

3) Most alcoholics drink because they like the taste of alcohol.

True ☐ False ☐

4) Alcoholism is a symptom of an emotional disturbance.

True ☐ False ☐

5) Once an alcoholic has remained sober for several years, he can return to moderate drinking.

True ☐ False ☐

6) Heavy drinkers build up a tolerance for alcohol which requires them to drink more and more to get the desired effects.

True ☐ False ☐

7) The alcoholic has a basic dissatisfaction with himself and/or his environment.

True ☐ False ☐

QUIZ

How much do you know about alcohol and alcoholism? Mark your answers, then turn to page 30 and check your Al-Q.

8) People who are wealthy, have good jobs, nice families and who come from good homes will never become alcoholics.

True ☐ False ☐

9) Some people become alcoholics from their first drink; others may take as long as 20 years.

True ☐ False ☐

10) Psychotherapy is of great aid to the alcoholic in helping him understand and deal with his basic problems.

True ☐ False ☐

11) An alcoholic can quit drinking once he makes up his mind to become sober.

True ☐ False ☐

12) A wife can help her alcoholic husband by nagging and threatening him into sobriety.

True ☐ False ☐

13) A husband of an alcoholic can help his wife by criticism and blame.

True ☐ False ☐

14) The best way to cure a cold is through drinking an alcoholic beverage.

True ☐ False ☐

The Nurse Meets The Alcoholic

(Continued from page 7)

who shows no insight into his problem. Although he sees the disastrous results of excessive drinking, he feels that this couldn't happen to him. "He can take it." The concern which he expresses about himself is usually on a verbal level. Unconsciously he assures himself that he is not concerned by his helplessness. When such an attitude prevails, it places a stumbling block in helping the patient recover and one which the nurse may find difficult to overcome.

The alcoholic's attitude towards drinking may show fluctuation from day to day. Here again, the nurse must be patient and not use pressure. She becomes alert to any indications of interest on the part of the patient's seeking help and summons such help while the patient is motivated.

Nurse Lends Support

The nurse must do everything possible to build the alcoholic's self-esteem. She must give him praise and recognition when indicated. She should encourage recreational activities and join in these activities herself. She must show the patient that she is sincerely interested in helping him get well. She must be a good listener, allowing the patient to verbalize his problems, watching for slips of the tongue and casual comments which can be meaningful to her and to the physician as well. By her close observation of the patient and her accurate reporting of his emotional reactions, she becomes a valuable member of the therapeutic team.

In group therapy, the nurse also plays an important role, but before she can participate effectively, she needs to know the nature of group therapy and the activities which might occur in a group situation. She needs to know the extent to which she will be involved and the possible reactions of members of the group toward her. As an authority figure, should she be a head nurse, a supervisor? She needs to be prepared for this necessity for assuming various roles within the group. The psychiatrist or clinical psychologist can be helpful in this area by preparing the nurse through individual conferences, or by participation in seminars.

Improvement—Not Cure

We all need to think of the alcoholic in terms of improvement rather than of cure. When through treatment, he is able to maintain sobriety for a period of several months, rather than just a few days or weeks, we have accomplished a great deal even though he may return to drinking. Our job is to guide and rehabilitate the alcoholic. This often requires much patience, sometimes more than we knew we had. But when an alcoholic is in treatment, he needs support and acceptance. He is worthy of the best efforts on the part of the nurse.

ANSWERS TO ALCO-FAX QUIZ

1. False. 2. False. 3. False. 4. True. 5. False
6. False. 7. True. 8. False. 9. True. 10. True.
11. False. 12. False. 13. False. 14. False.

The Tension Years

(Continued from page 27)

rage was directed at his father for his cruelty, and later it was unconsciously transferred to all persons in authority over him. The foreman became Dad-in-overalls. The plant manager represented to Jim, Dad-in-a-business-suit. But Jim couldn't bring himself to express his anger openly ("Dammit, boss, don't watch me so close. You give me the jitters.") He had heard others say such things but he feared the wrath of his superiors. Instead, Jim "got back" at the boss in devious ways—by making costly mistakes, inefficient performance, and finally by quitting a job before giving the boss the "satisfaction" of firing him.

Through the effects of alcohol, Jim found two-way relief, better than any patent medicine could supply. The obvious problem—his feelings of failure over inability to hold a job—was temporarily blotted out. And alcohol effectively anesthetized the personality problem—repressed hostility—too, allowing Jim to blow off steam without fear of reprisal. No wonder alcohol became so important and necessary to this young man.

The cases of Ralph and Jim typify the kinds of problems which seem to be related to the high rate of alcoholism among young adults. Basically, they are only the ordinary everyday adjustments of adult living—marriage, job, etc. They become a threat to emotional balance when early experiences fail to provide sturdy personality footings which prepare the individual to meet and master each new life adjustment confidently and comfortably.

Ralph, for example, was faced with the very real problem of how to live comfortably with a spoiled, demanding wife. There must be hundreds and thousands of other men who have made this adjustment without undue stress or anxiety. But Ralph could not because he wasn't prepared through previous life experiences. He is still a child emotionally, excessively dependent on others, though physically he is a grown man.

Jim had to learn to hold a job. So do most men. And most are able to learn without holding and losing a dozen different ones. But Jim's personality difficulties kept getting in the way of his progress.

The kinds of practical problems which precipitate young adult alcoholism may center in the marriage relationship, sexual adjustment, job or profession, financial responsibilities or in still other areas. The underlying faulty personality traits will vary with individuals, though overdependency or repressed hostility crop up in a surprisingly large number of cases.

What makes young adulthood a vulnerable age for the disease of alcoholism? Problems plus personalities. The problems are the same, just numerous. The personalities are different—some are prepared to master the problems and others are not. If you're in the age group from 25 to 35, how do you rate your own personality resources? Are you susceptible to alcoholism?

(In the next issue of INVENTORY we will discuss ways of preventing the high occurrence of alcoholism in young adults. We will see that persons already within this "danger zone" can take positive steps to build up their immunity to alcoholism and other forms of emotional illness. The vital role that today's parents of tomorrow's young adults play in prevention will be explored also. Watch for the sequel to this article in the September-October issue of INVENTORY.)

To Help a Friend Who Is An Alcoholic . . .

1) Study informational material about alcoholism. Learn as much about the nature of the illness as you can.

2) Don't condemn or lecture your friend about his alcoholism. Make him feel that you are sympathetic toward him and truly want to help.

3) Remain as completely objective in your relationship with him as you can. You will be of greater help to him if you are not emotionally involved. You are also in a better position to teach and inform him about his illness and to outline constructive plans of action.

4) Instigate discussions of drinking and alcoholism. In this way, you will be able to get across the information you have gained about alcohol and alcoholism.

5) Don't pressure him when discussing alcohol and alcoholism. Tell him all you know about the illness and then be content to let him absorb and apply as much of the discussion as he wants.

6) Learn about alcoholics who have achieved sobriety and then assure your friend that he also can become free of his compulsion. Compare his case to those of sober alcoholics and suggest examples for him to follow.

7) If possible, introduce him to a recovered alcoholic who can help him achieve sobriety through personal relationships and/or AA. However try not to make the introduction look contrived.

8) Try not to make him feel that you are interfering. This will cause him to resist your help. Be friendly in your approach.

9) Never be afraid to bring up the subject of alcoholism. Discuss it in a friendly, not lecturing manner.

10) *Never,* unless there is no other way, cut off your friendship. He needs you now more than ever. If all other methods have failed, tell him that you're breaking off your relationship and you'll be glad to resume it when he decides to do something about his drinking. Above all, let him know that you will always be his friend.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

Doc.
N.C.
Doc.
Carolina State Library
Raleigh

SEPT.-OCT., 1957

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

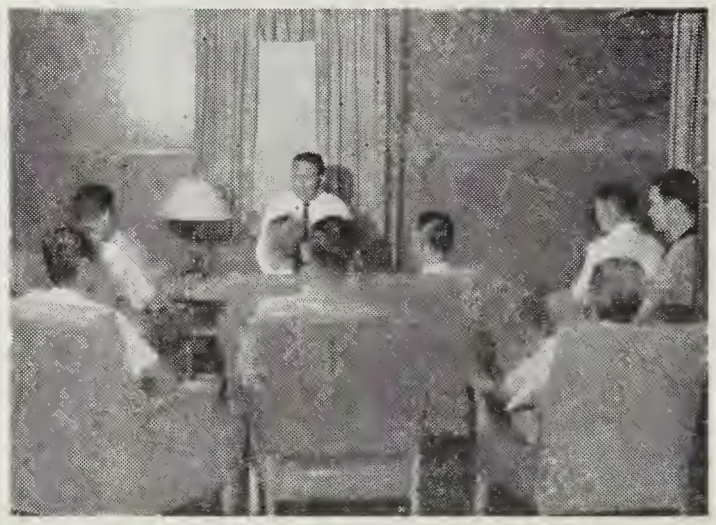
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

VOLUME VII NUMBER 3

SEPTEMBER-OCTOBER, 1957

RALEIGH, N. C.

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH: The North Carolina State Prison now has a Supervisor of Alcoholic Rehabilitation, D. S. Godfrey of Salisbury. This office was set up by the 1957 General Assembly and represents the efforts of the Prison Department to rehabilitate alcoholic inmates. Godfrey will work closely with the AA organizations in the State in carrying out this program in the Prisons.

SOUTH CAROLINA. The 1957 Legislature passed a bill initiating a program of alcoholic rehabilitation in South Carolina. An alcoholism board has been appointed and thus far they have had one meeting.

WASHINGTON STATE: The Washington State Legislature has appropriated $250,000 to launch a state-wide alcoholism control program. Under the new law, the Washington State Department of Institutions will be charged with establishing and administering the program, selecting personnel and needed facilities.

NORTH CAROLINA: The NCARP has prepared a directory of treatment facilities available to alcoholics in North Carolina. The directory includes all in-patient and out-patient facilities within the state and will be of particular interest to ministers, physicians and professionals in the field of alcoholism. Included in the directory is a detailed description of each establishment: modes of therapy, required length of stay, rates, admission requirements, staff, facilities for the acutely ill or intoxicated patient and provisions for charity patients.

WASHINGTON, D. C. The National Safety Council has reported that 200 people died over the July Labor Day weekend in traffic accidents involving alcohol. Further studies showed that 50% of all highway fatalities are "alcohol-flavored."

ALABAMA: On August 28, the Governor of Alabama signed a bill authorizing the Commission on Education with Respect to Alcoholism to establish outpatient clinics for limited care and treatment of alcoholics. The Commission was appropriated $150,000 each year of the next biennium for carrying out such treatment. The Commission is now making plans for the establishment of outpatient clinics and is looking for an administrator to head the Program.

NEW YORK: The story of AA, as told by its co-founder, Bill W., "Alcoholics Anonymous Comes of Age" has just been published and is now ready for distribution. Word from the publishers says that orders will be filled on a first-come first-serve basis. The book contains sixteen pages of photographs, pictures of many of AA's non-alcoholic friends from the pioneering days of AA and shots of historic homes, places and objects. There are 500 pages in all. Orders should be sent to AA Publishing, Inc., Post Office Box 459, Grand Central Annex, New York 17, New York. Price, $4 to individuals, $3.50 to AA groups.

NORTH CAROLINA: The 1957 Institute for Social Workers and Public Health Nurses was held September 16 at Wilmington. The Institute was held for the benefit of nurses and social workers living and working in Wilmington and surrounding counties. Dr. Norbert Kelly and Miss Roberta Lytle of the NCARP office were invited by Mrs. Emma Howell of the Family Service Agency to conduct a one-day session on the personality of the alcoholic and medical problems associated with alcoholism.

STOCKHOLM: The NCARP office has received word from Arne Skutin of the Stockholm Commission on Alcoholism that he has arrived safely back in Stockholm after his tour of various alcoholism programs in the United States. Mr. Skutin was in Raleigh for several days and then continued on to Chicago and points west. His visit, sponsored by the Swedish Government, was for the purpose of gathering material on alcoholism programs in the States which could be utilized by the Stockholm Commission.

CALIFORNIA. The North American Association of Alcoholism Programs will hold its annual meeting in Berkely, October 28-31. Harold B. Jamison, NAAAP program chairman, reports 45 persons representing 24 state and four provincial programs have given notice they will attend. The program will include reports and papers on significant scientific work in alcoholism, group discussion, panel and individual critiques. Dr. E. M. Jellinek, internationally known authority on alcoholism, has accepted an invitation to address the Association. The NCARP will be represented at the meeting by its Director, S. K. Proctor.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

WHILE July 1st marked the beginning of our new fiscal year, September seems to more nearly mark the beginning of the new year as far as professional activities are concerned. Much of July and August was taken up by vacations, closing out the old year's functional and clerical business, making financial reports, and participation in the summer schools and other summer conferences and institutes.

September finds us like scores of other government agencies and organizations, busily preparing for a 12-month schedule of activities.

We have been planning and building a new exhibit on alcoholism for display at the State Fair to be held October 15th in Raleigh. During the next year, we will take this new exhibit, along with our regular displays, to county fairs, institutes and seminars and the district conventions of the North Carolina Educational Association.

Literature Depleted

Fortunately, most of our educational literature has been depleted. This is good news to us since it means our readership and distribution is spreading wider each year. We're now arranging with the publishers for a new supply which entails re-evaluation of our previously-used literature, plus re-writing and revising.

We sincerely hope that within the next 12-months, we shall be able to sponsor and develop a conference on Alcoholism in Industry. In the meantime, we continue to carry out plans for the 1957-58 conference for ministers, nurses and teachers. We're already planning the curriculum for the 1958 Summer Studies on Alcohol offered for the past several years.

Along with these thoughts for the future must go our regular everyday activities, correspondence, speaking engagements, conferences and clerical and administrative work.

WE'VE been pleased to receive word from Dr. Stuart Chapin, Chairman of the Citizens Committee on Alcoholism in Asheville, N. C., that their organization has incorporated. Their charter has been filed with the Secretary of State and they are now ready to adopt a constitution and by-laws. Their new status means the development and extending of their various services in the area of education and rehabilitation to the greater Asheville area.

We should also like to offer our best wishes for success to a group now forming in Greenville, N. C. who are considering the establishing of the Pitt County Citizens Council on Alcoholism.

The NCARP stands by willing to help any committee or group in North Carolina in the formation of a Citizens Committee in their area.

VOL. VII, No. 3 INVENTORY SEPT.-OCT., 1957

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Alateen—it's a new movement designed for the youngsters of AA's. Here's how it works.

IT'S A TEEN-AGE AFFAIR

Reprinted by Kind Permission of The AA GRAPEVINE

PERHAPS at last night's meeting you heard an AA speaker remark, "I started to drink at the age of thirteen and believe I was an alcoholic from the start. I wish that I had known of AA and this disease then. Maybe I could have saved myself a lot of miserable living."

Most of us have heard statements similar to this many times in AA but we may be hearing it less in the future. In fact newcomers may even become hard to find at all if the teen-age movement started in California continues its rapid snowball progress.

Named Alateen by its youthful members, its beginning is almost as inspiring as AA's. Its rise is almost as phenomenal and its motives and success just as vital to useful, happy living. Like AA it was the inspiration of one person, a young high school boy whose father had been a drunk. The father, through the teachings of Alcoholics Anonymous, was trying to create a new atmosphere of home life for his family.

Bob is a typical high school lad interested in sports, out-of-doors, hot rod cars and of course, girls. After

Bob's dad had been in AA for a short time Bob got into a bit of disciplinary trouble with school officials. The trouble was of a sufficiently serious nature that his educators wanted to place him in a special school for problem children. Bob's mother, active in an Al-Anon Family Group, begged the school officials to give them one more chance.

She and Bob's dad spent an evening with the boy, explaining the exact meaning and promise contained in the Twelve Steps of AA. They asked him to try and apply them in his problem at school. Having a sincere desire to correct the trouble, Bob did try. From this point on he began to attend the Al-Anon Family Group with his mother and an occasional AA meeting with both parents. He felt, in these adult meetings, a wide divergence between the experience and needs of their problems and his. One night he explained his frustration to his parents and presented the idea of forming a group of teen-age children of Alcoholics Anonymous members for the purpose of sharing their experience, strength and hope with each other. Thus Alateen was born.

First Meeting

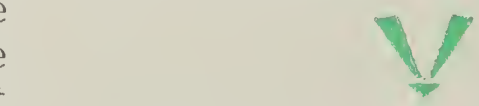
Bob contacted his dad's AA acquaintances and learned of other teen-age children in AA families. On a Wednesday night the first meeting was held in Pasadena in the kitchen of the AA meeting place. Five other young people attended that first gathering. Bob told them his idea, a little of what he had been like, what had happened and what he was like now. He explained how the Twelve Steps had helped him. He thought the truths of AA could aid them toward living happier, more useful and less delinquent lives. His proposal was met with so much enthusiasm that a name was voted upon that same evening. Today, less than a year later, the Pasadena Group has twenty-three active members.

The usual problems of formation occurred. Most of these problems were ironed out with the aid of older AA and Al-Anon members. Because they found that most younger children did not understand the exact nature of the program and because some un-thinking AA's were using Alateen for a free baby-sitting service, they established an age limit of thirteen to twenty. Like Al-Anon, Alateen is separate from AA, but also like Al-Anon it is an important companion program for the alcoholic's family. These young people, having once learned of and accepted the explanation of the alcoholic problem in the family, go forward applying the principles of AA to their own personal behavior problems.

With a few minor changes, they make use of AA's Twelve Steps and Twelve Traditions in their daily living .The Serenity Prayer is an important part of their living. They use AA mottoes and have composed other bits of prose to aid them in living happy, cooperative and useful lives.

Meetings Similar

An Alateen meeting is conducted in exactly the same manner as an AA meeting. Each meeting finds an invited AA and Al-Anon in attendance. They have no voice in the meeting, voting, planning or conduct of it. Occasionally AA guest speakers are invited to aid the new Alateen member in getting a better understanding of the alcoholic problem and the dis-



And it was W. C. Fields who made this classic remark: "I just can't understand how the human race is going to survive, now that the price of living has gone up $2 more per quart."

ease of alcoholism. Al-Anon speakers present their message to help the youngsters in learning to accept the alcoholic problem in their home.

Internal group problems are handled strictly on the basis of AA tradition. Anonymity is respected and demanded more strongly by Alateen than our Traditions actually call for. Placing principles before personalities is the guide phrase of these guys and gals. One group augmented the idea by having dancing during the after-meeting social time. This practice has been halted without any outside pressure for the members decided that such activity might soon cause them to forget the evening's message of help. This group now holds a teen-age hop on a night other than meeting night. They extend an invitation to all teen-age couples in the area.

Several Alateen members do not have alcoholic problems in their families. They either contacted Alateen out of attraction or because some Alateen member mentioned the help he was gaining from the program. At first "non-alcoholic problem" members presented the question of violation of the anonymity tradition. With deep understanding, Alateens talked with their parents and concluded their primary duty was to aid those juveniles who had a desire for better behavior. These "outside the problem" members, as good Alateens, respect and adhere to the anonymity traditions.

Alcoholics Anonymous has now truly become a family affair in those areas which have all three of these programs. Quite often all three meetings are conducted in the same building on the same night. The social time after meetings often finds all three participants mingling together, eating doughnuts and drinking coffee or soda pop.

I have a sixteen-year-old son who is a member of an Alateen Group. I have been invited to sit in at their meetings and also to speak. I sat in on a recent meeting of the original group in Pasadena. Because of the alcoholic problem in their families two of the girls, both seventeen, are now wards of the juvenile court. One is the oldest of five girls and all are now living in separate foster homes. Both parents are still practicing alcoholics but through the teachings of Alateen she is now able to understand them. Because of resentment and lack of proper supervision her thought patterns led her into running away from home, direct insubordination to parents and school officials and general lack of responsibility. She is now a fine young lady, attractive, intelligent, with fine inner qualities that are beginning to blossom forth because of her Alateen program.

The other seventeen-year-old girl ran away from home after her dad came to AA. She had more or less assumed his place beside her mother during his drinking days and she couldn't easily relinquish her station when he became sober. She ran away from home, skipped school flagrantly broke school and social regulations

A small boy lost himself at the auto show. He was crying loudly when a policeman found him and asked him what was the matter. "I'm lost," said Charley.

"Oh," said the policeman. "Who were you with?"

"My father," said the lost child.

"And what's your father like?" the officer asked.

"Beer and women," sobbed Charley.

—From CHIT-CHAT

until at last it was necessary for her parents to ask juvenile authorities to aid them. The court placed her in a foster home. While residing there she began going to Alateen. Today she is back in her own home and living in harmony with her family and friends. Citizenship grades for both these girls have remained consistently high since coming to Alateen and both have raised their scholastic standings at school.

One of the boys at age eighteen decided he wanted to get married. His still practicing alcoholic mother forbade this so he ran away from home. He moved in with a fast crowd of older fellows and soon found himself using sedatives for kicks and stealing auto parts for expense money.

The desire to do things right drove him back home where he discovered AA had entered his home. His mother suggested Alateen to him and he went to his first meetings for laughs. He hasn't missed a meeting since. He has been able to unburden his resentments and big-shot attitude to kids who understood. Today his wrong habit patterns and adverse thinking are under control. His parents, family and friends overflow with praise for Alateen which has saved him from himself.

Heading Astray

These are the exceptional cases. Most of the kids have never strayed that far from proper behavior but they will readily tell you that they were heading that way.

The majority are applying their program to normal teen-age difficulties. They are trying to overcome problems of disobedience, resentment, lack of responsibility, boredom, disrespect, smoking, staying out past parents' curfew hours and, as my own son puts it, just plain laziness.

Each week the members of the Pasadena Group select a personal problem they feel they need to correct. They apply the idea of living one day at a time to the problem. The following week they report to the group on their progress.

In answer to my queries about the spiritual concepts of the program, members agreed that the Serenity Prayer and finding a God of their understanding made the Alateen way easy. Most are going to church now without their parents' insistence. Most admitted asking for guidance during the day.

Word of this new teen-age program spread. Soon inquiries were pouring into the Los Angeles AA Central Office. The Pasadena Group visited other areas to explain their program and help form new groups. The effort to carry their message has resulted in nine other active groups in the Los Angeles area. They now receive and handle Alateen Twelfth Step calls in the same manner as AA and Al-Anon. A few calls come in from AA Central Office, although more are passed on to them from AA Twelfth Step calls when it is discovered there are teen-agers in a newcomer's family.

These are facts about teen-aged kids like yours and mine—the kind of kids that church leaders, juvenile authorities and school officials are seeking a way to handle. Alateens believe that they may have the answer to the delinquency problem if they can just get it to the sources that count—other teen-agers like themselves. I can't help but agree. I am seeing it work every day. I experience the benefits in my own home.

I left that Pasadena meeting knowing that I had had another spiritual experience. I thanked God that some twenty years ago he had placed the right message in the right hands at the right time.—*Bill M., La Puente, Calif.*

SLIPS

more than normal | alcoholic?

Do alcoholics suffer from "alcoholic behavior" or are they simply victims of human nature?

BY THE LATE WILLIAM D. SILKWORTH, M.D.

THE mystery of slips is not as deep at it may appear. While it does seem odd that an alcoholic who has restored himself to a dignified place among his fellow-men, and continued dry for years, should suddenly throw all his happiness overboard and find himself in mortal peril of drowning in liquor—often the reason is very simple.

People are inclined to say "There is something peculiar about alcoholics. They may seem to be well, yet at any moment they may turn back to their old ways. You can never be sure."

This is largely twaddle. The alcoholic is a sick person. Under the technique of Alcoholics Anonymous he gets well, that is to say, his disease is arrested. There is nothing unpredictable about him any more than there is anything weird about a person who has arrested diabetes.

Let's get it clear, once and for all, that alcoholics are human beings just like other human beings—then we can safeguard ourselves intelligently against most of the slips.

Both in professional and lay circles, there is a tendency to label everything that an alcoholic may do as "alcoholic behavior." The truth is, it is simply human nature.

It is very wrong to consider many of the personality traits observed in liquor addicts as peculiar to the alcoholic. Emotional and mental quirks are classified as symptoms of alcoholism merely because alcoholics have them, yet these same quirks can be found among non-alcoholics, too. *Actually they are symptoms of mankind.*

Ordinary People

Of course, the alcoholic himself tends to think of himself as different, someone special, with unique tendencies and reactions. Many psychiatrists, doctors and therapists carry the same idea to extremes in their analyses and treatment of alcoholics. Sometimes they make a complicated mystery of a condition which is found

in all human beings, whether they drink whiskey or buttermilk.

To be sure, alcoholism, like every other disease, does manifest itself in some unique ways. It does have a number of baffling peculiarities which differ from all other diseases. At the same time, many of the symptoms and much of the behavior of alcoholism are closely paralleled and even duplicated in other diseases.

The alcoholic "slip", as it is known in Alcoholics Anonymous, furnishes a perfect example of how human nature can be mistaken for alcoholic behavior.

"Slip" Identified

The "slip" is a relapse! It is a relapse that occurs after the alcoholic has stopped drinking and started on the AA program of recovery. "Slips" usually occur in the early stages of the alcoholic's AA indoctrination, before he has had time to learn enough of the AA technique and AA philosophy to give him solid footing. But "slips" may also occur after an alcoholic has been a member of AA for many months, or even after several years, and it is in this kind, above all, that one finds a marked similarity between the alcoholic's behavior and "normal" victims of other diseases.

No one is startled by the fact that relapses are not uncommon among arrested tubercular patients. But there is a startling fact—the cause is often the same as the cause which leads to "slips" for the alcoholic. It happens this way:

When a tubercular patient recovers sufficiently to be released from the sanitarium, the doctor gives him careful directions for the way he is to live when he gets home. He must be in bed every night by, say, eight o'clock. He must drink plenty of milk. He must refrain from smoking. He must obey other stringent rules.

For the first several months, perhaps for several years, the patient follows directions. But as his strength increases and he feels fully recovered he becomes slack. There may come the night when he decides he can stay up until ten o'clock. When he does this, nothing untoward happens. The next day he still feels good. He does it again. Soon he is disregarding the directions given him when he left the sanitarium. Eventually he has a relapse.

In Cardiac Cases

The same tragedy can be found in cardiac cases. After the heart attack, the patient is put on a strict rest schedule. Frightened, he naturally follows directions obediently for a long time. He, too, goes to bed early, avoids exercise such as walking upstairs, quits smoking and leads a Spartan life. Eventually, though, there comes a day after he has been feeling good for months, or several years, and has recovered from his fright. If the elevator is out of repair one day he walks up three flights of stairs. Or he decides to go to a party—or do just a little smoking, or take a cocktail or two. If no serious after-effects follow the first departure from the rigorous schedule prescribed he may try it again, until he suffers a relapse.

In both cardiac and the tubercular cases, the acts which led to the relapse were preceded by wrong think-

Night after night the man took his place at the far end of the bar and drank one Manhattan after another, all alone. What attracted the curiosity of the bartender was the man's habit of taking out the cherry and replacing it with a glass eye. Finally, he could stand it no longer so he asked the lone drinker why.

"I'm lonely," said the man. "And when I say, 'Here's looking at you!' I like to have something looking back at me!"

ing. The patient in each case rationalized himself out of a sense of his own perilous reality. He deliberately turned away from his knowledge of the fact he had been the victim of a serious disease. He grew over-confident. He decided he didn't have to follow directions.

Now that is precisely what happens with the alcoholic—the arrested alcoholic, or the alcoholic in AA—who has a "slip". Obviously he decides again to take a drink sometime before he actually takes it. He starts thinking wrong before he actually embarks on the course leading to a "slip."

Not Alcoholic Behavior

There is no more reason to charge the "slip" to alcoholic behavior than there is to lay a tubercular relapse to tubercular behavior or a second heart attack to cardiac behavior.

The alcoholic "slip" is not a symptom of a psychotic condition. There's nothing "screwy" about it at all. *The patient, didn't follow directions.*

And that's human nature! It's life! It's happening all the time, not merely among alcoholics, but among all kinds of people.

The preventive is plain. The patient must have full knowledge of his condition, keep in mind the facts of his case and the nature of his disease and follow orders.

For the alcoholic, AA offers some directions. A vital factor, or ingredient, of the preventive, especially for the alcoholic, is sustained emotion. The alcoholic who learns some of the technique or the mechanics of AA but misses the philosophy or the spirit, may get tired of following directions—not because he is alcoholic but because he is human. Rules and regulations irk almost anyone, because they are restraining, prohibitive, negative. The philosophy of AA, however, is positive and provides ample sustained emotion—a sustained desire to follow directions voluntarily.

Psychology No Different

In any event, the psychology of the alcoholic is not as different as some people try to make it. The alcoholic has problems peculiar to him, perhaps, in that he has been put on the defensive and consequently has developed nervous frustrations. But in many instances there is no more reason to be talking about the "alcoholic mind" than there is to try to describe something called the "cardiac mind" or the "TB mind".

I think we'll help the alcoholic more if we can first recognize that he is primarily a human being—afflicted with human nature.

DEPENDENCE ON ALCOHOL

EVEN when a person recognizes his dependence on alcohol and the complications it brings, he is, like many others with psychologically engendered patterns of illness, unwilling or unable to be relieved of his symptoms. This is not surprising if we think in very simple terms of the alcoholic as a person whose conflicts have allowed him to be diverted farther and farther from human relationships, and who has found comfort, courage, or escape in the use of alcohol. Long habit has reinforced this learned experience and alcohol has become the logical solace in any difficulty.

—John D. Armstrong, M.D., Medical Director
Alcoholism Research Foundation, Ontario, Canada

THE AJAX COMPANY

Anytown, U.S.A.

N.C.A.R.P.
15 West Jones St.
Raleigh, North Carolina

Dear Sirs:

One of my best men shows all the signs of being an alcoholic. When he's sober he can really turn in the orders, but when he's drinking, he's of no use to us at all. What can I do?

Sincerely yours,

John Employer

John Employer
President

JE:rm

Do you, like Mr. John Employer, have an alcoholic problem in your office or plant? Then read this open letter

Dear Mr. Employer . . .

SOMETIME ago the following letter was received at the ARP office from a North Carolina employer, Mr. D. L.

"A salesman who has been with us for over a year is now an alcoholic patient at Butner. We hired him with full knowledge of his drinking, but with the understanding that if alcohol interfered with his work, we would have to let him go. This was perfectly agreeable to this man and he has made us an excellent salesman. However, he did not live up to his side of the bargain and his work fell down badly. The result is that he's at your hospital.

I am writing to ask whether or not this man justifies a second chance or whether you think the situation is more or less hopeless.

It doesn't do our company any good to have one of our men drinking to excess."

Here is a problem that comes up time and time again. What position should you or another person in authority take when confronted with the problem of an alcoholic employee? If his excessive drinking is interfering with his work capacity, should the alcoholic be fired outright? If not, should he be given a second chance? What bearing should the fact that the alcoholic is seeking treatment have on your decision?

Understanding Necessary

First of all, it is necessary for you to understand the disease, alcoholism. It's an emotional illness which cannot be controlled by exercising willpower. It generally takes a long period of social drinking before an individual becomes addicted to alcohol and a drinking pattern established over a ten or twenty year period cannot be changed overnight or even during a 28-day stay at Butner. But once in treatment, the alcoholic's chances for sobriety are good.

Secondly, the alcoholic can never be "cured." That is, he will always be an alcoholic, just as one afflicted with diabetes is always a diabetic. However, alcoholism, as diabetes, can be controlled, hence the term "recovered" alcoholic. The recovered alcoholic can maintain control over his illness only so long as he never takes another drink. If he wants sobriety he must abstain from alcohol just as the diabetic must abstain from sweets.

Thirdly, no matter how long an alcoholic has remained sober in the past, there is never a guarantee of

continued sobriety. *At any time,* the recovered alcoholic can revert to his past drinking pattern. However, during long-term sobriety, the alcoholic may be building up inner resources which will act as a bulwark against undue pressure and strain. These resources might prevent any relapse into the old drinking pattern.

Treatment at Butner or at any other rehabilitation center is only the beginning of sobriety. In most cases, complete rehabilitation includes follow-up treatment at a Mental Hygiene or Alcoholism Clinic and/or membership in AA. If through these resources the alcoholic can gain an understanding of the reasons why he drinks excessively and thus learns to deal with his problems, his chances for long-term sobriety are good.

When you, the employer, understand that alcoholism is an emotional disturbance which cannot be cured but can be arrested, you are then in a good position to evaluate the wisdom of whatever action you take with your alcoholic employee.

Guarantee Wanted

Mr. D. L. is faced with the decision of whether or not to keep his salesman on the job. The salesman is now receiving treatment at Butner, but Mr. D. L. wants some sort of guarantee that if he lets him keep his old job, he will stop drinking. He feels that this salesman has previously let him down by drinking during working hours. He fears that if he reverts to excessive drinking again, his behaviour will reflect upon his company and, if he's a good businessman, he wonders how much it is actually costing the company in dollars and cents to keep this man on the payroll.

Unfortunately no one can ever be sure if a man will maintain complete sobriety after undergoing a period of treatment. On the average, approximately 55 percent of the Butner patients are still sober one year after they leave the Center. Many of the patients maintain sobriety indefinitely after undergoing treatment. Others, however, relapse into excessive drinking almost immediately upon leaving Butner. To a great extent, a man's sobriety after treatment depends upon himself, his motivations for sobriety and the social conditions under which he lives.

Inasmuch as there is a chance that an alcoholic will remain sober after leaving Butner, Mr. D. L. would be making a contribution toward his employee's recovery by permitting him to continue his work with the company, despite the fact that there is no guarantee that he will remain sober any definite length of time. If the employee remains sober, he might become the best salesman Mr. D. L. has ever had, as many recovered alcoholics are famous for their "get up and go." Without alcohol to interfere with his work capacity, it is possible that he will more than repay Mr. D. L. for his past losses and Mr. D. L., in turn, will have the satisfaction of knowing he had contributed to his employee's sobriety and success. If the employee does not remain sober, then admittedly, Mr. D. L.'s company will suffer. But the loss will not be so great as to overshadow the faith and support he has shown toward his alcoholic employee.

Acceptance

Once Mr. D. L. decides to keep his employer on the job, he must *never* treat him any differently from the rest of his employees. He should not single the alcoholic out or make a special case of him other than letting him know that his employer is interested in him and wants to help him. Acceptance means everything to the alcoholic. Above all, it means that someone has confidence in him. This,

in turn, gives the alcoholic confidence in himself.

Suppose, however, that Mr. D. L. cannot bring himself to keep an alcoholic on his payroll. He has nothing against the man personally. He just doesn't like alcoholics. And no amount of talking or persuading can convince him that alcoholism isn't a symptom of lack of will power or just plain "no countness." If this is the case, the kindest thing he can do for his employee is to let him go from the company. If the alcoholic stays with his job, and realizes the resentment and hostility felt against him, whether expressed or not, this situation could be completely demoralizing and cause much harm.

Desires Recovery

The very fact that an alcoholic employee is in treatment is often proof of his desire to recover. This fact bears strong weight with many employers since they feel that once a man has done something concrete about his drinking, he is worth any help and encouragement they can give. Some of you employers wish to learn about the illness yourselves and read periodicals, brochures and other educational materials on alcoholism. In that way, you become better acquainted with all aspects of the disease and know its effects on the alcoholic.

Many alcoholics have similar personality characteristics which can cause you, the employer, many headaches. The problems which sometimes show themselves at work are usually temper flare-ups, lateness, refusal to do the work required of him, drinking on the job, resisting authority, irritability, unaccountable absenses and an increasing number of "colds" and "sore-throats." The best defense you can have against these undesirable traits is to realize they are symptomatic of alcoholism and probably would not show themselves if the alcoholic were recovered.

Alcoholism Possible

When it becomes apparent that one of your workers is exhibiting many or all of these characteristics, it would be well for you to investigate the possibility that he is in the throe of uncontrolled drinking. If you find that he is an alcoholic, then is the time for you to become a friend, as well as a supervisor. Try to get his confidence. Suggest he see a doctor or go to a treatment center. Bring the subject of alcoholism and your knowledge of his situation out in the open. Have a frank talk with him about his illness. He will probably get on the defensive and might even turn belligerent about your "nosiness," but he may remember your words and your offer of help.

Contact Physician

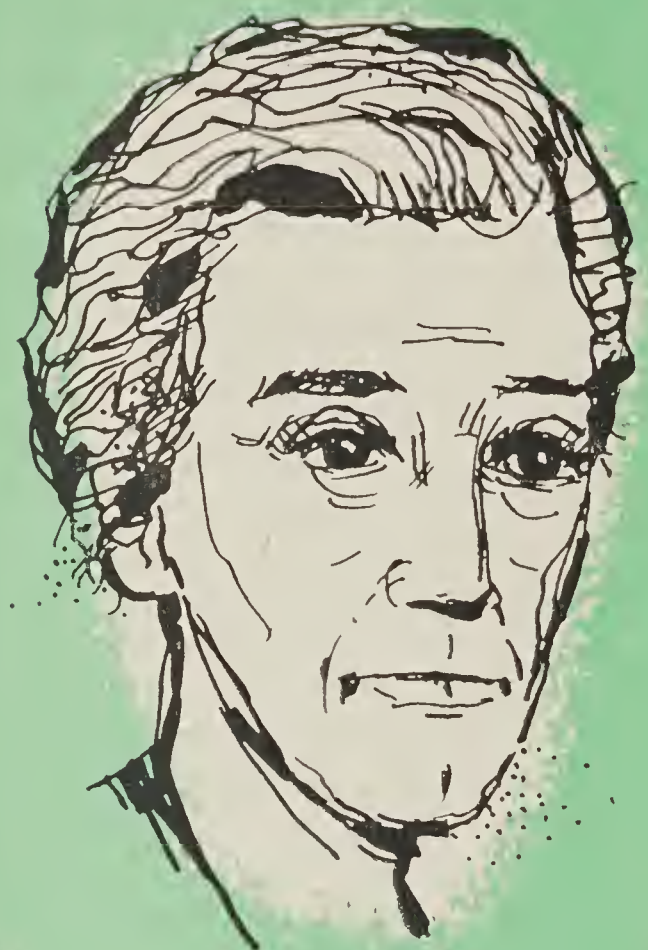
If possible, find the name of his physician and contact him yourself. Tell him all you know about your alcoholic employee and enlist his aid. His physician will be able to discuss alcoholism from a medical standpoint and might give you many pointers on how to handle your particular problem.

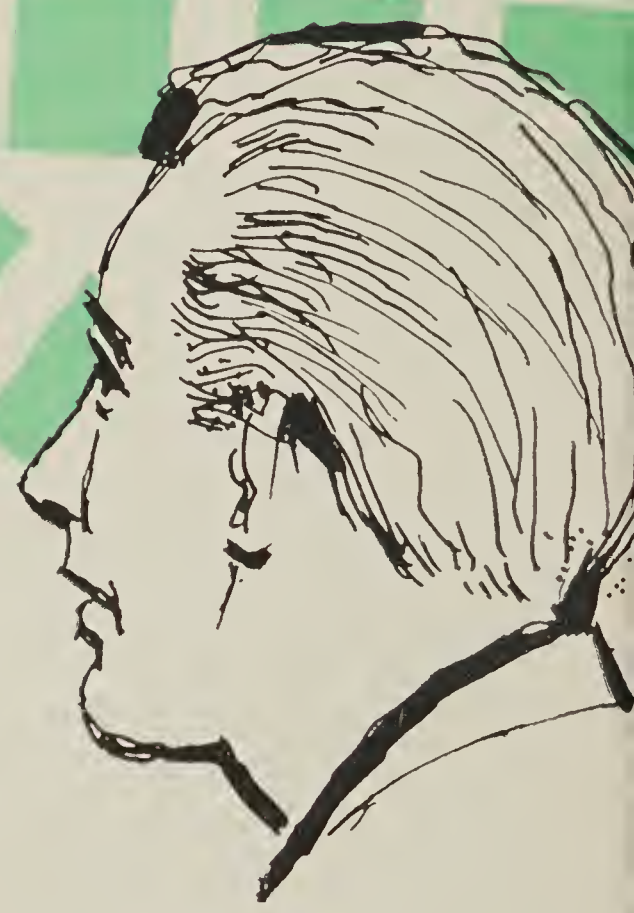
One thing you should bear in mind is that your worker will probably feel resentment at your concern. He might feel you're "ganging up" on him and become antagonistic. But don't be alarmed and by all means, don't give up. Antagonism and feeling that no one understands are all part of being an alcoholic.

Catch the signs of alcoholism in your company early and then put on a campaign to help rehabilitate those needing help. Your reward will be increased efficiency and profits, and knowing you've helped a down-trodden man hold his head up high again.

Don't blame Mom for

I MUST





A Man Speaks ...

WHAT did the doctor mean when he said, "Bob, if you want to get well, you will have to forgive your mother"?

What did he mean, forgive! Why, I'm the one who needs forgiveness. I hate *myself,* not my mother. I hate myself for the way I am. Take just the little things, like making a decision. I'm never safe unless I ask Mary first, or my mother. And like when I disagree with my boss. Why do I weasel out every time it comes to a showdown? My brain clicks just as fast as his. And afterwards I get so mad at him for being so darned overbearing. Why don't I speak my piece? I guess for one thing I'm afraid he won't like me. That's it! I'm afraid of losing his friendship. Well, what kind of a guy is he if my being honest will make him think less of me? What's he paying me for anyway? To be a mealy-mouth?

How did I ever get this way? Come to think of it, this has been going on a long time. Like back in high school. Getting in good with the coach. Hanging around the teacher in grade school. And even before that! I was Mom's good boy. Yes, "Mom's good boy". Always looking for that pleased look in someone's eye. Always gues-

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r troubles. She had her problems, too, and its no picnic being a parent.

ORGIVE MY MOTHER

A Woman Speaks ...

THE way you talk, Doctor, you'd think I was to blame for the kind of person I am. You must think Mother is a suffering saint and I'm a devil with horns. If you only knew!

Of course I haven't told you everything. How could I? I deserve some self-respect; "pride" Mother calls it. Goodness knows, if I left it up to her I'd have none at all.

"You aren't a bit like your Mother". I get that all the time. Why should I be? You want to be like someone who shows you that you mean nothing to her? What has she ever given me but a big hunk of cold shoulder? In return, I'm supposed to be her sweet, loving, obedient daughter, with accent on obedient.

She sure has the rest of the family buffaloed—Bill, Ginny, and even Dad. She's got *him* right where she wants him, between her thumb and forefinger. Well, she doesn't have me. If it weren't for Dad, I wouldn't feel as though I belonged to this family at all. He's the only one who really cares, but he, too, has to watch his step. Sometimes he gives me a little wink when Mother starts sounding off or he'll give me a hug when Mother isn't looking. Dad and I understand one another, but we'd

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A MAN SPEAKS . . .

sing what someone wants me to do or say, just as if I were a pet dog.

And then there's the office crowd. I get along with them all right. But how? By being the clown, the easy-going one, the life of the party. But never the leader. Not one among them knows what I really think. How I really feel. And they don't even care.

Who are my close men friends? Who do I trust? I never have felt sure of myself with other fellows, even as a kid. Never felt sure of myself with Dad. How could I? We never did much together by ourselves. Never talked "man talk" very much. I always felt much more comfortable around Dad when Mother was there too.

Dad used to laugh about my being "Mamma's boy," then he and Jack would go off to the ball game. They'd have bull-sessions out in the tool shed while I went shopping with Mom. I wonder if my dad ever really liked me? And Jack, he might as well have been somebody else's brother.

Then there's Mary. What is the matter with Mary? She isn't the same girl I fell in love with, or is she? Always wants me to go downtown with her. If I'm quiet two minutes she wants to know what's wrong. If I go for a pack of cigarettes, she wants to know where I'm going, how long I'll be gone. Where? When? What? Why? Until I think I'll yell "None of your d . . . business." When I'm drunk, I do yell it. Then she gets that sad, hurt look like Mom used to do when I'd not come straight home from school when she'd saved me a piece of apple pie. Or like the time I sneaked a cigarette with Jack behind the house and Mom caught us. Jack only looked disgusted but I worried for days.

Mary seems to be getting more tense and jittery too. Can I help it if I'm not Clark Gable? What kind of woman is she anyhow? That's what I ask her when I'm drunk. I thought I had married a sweet, unselfish girl like Mom. Yeah, like Mom.

Sometimes I get so mad at Mary I could kill her. Did I say that? I don't really mean it quite like that, but she says I do when I'm drinking. If I've got all *that* stored up inside it must have been accumulating a long time. The Doc says a lot of your angry feelings come from frustration. Well, I must have had a lot of it. In a way, that's what Mary does to me. Makes me feel like a kid half the time. She says I ought to stop acting like one. Says I never take the responsibility for making decisions. Says I always wait for her to make the first move. What's wrong with that? Mom always made the decisions at home. Why, she even told me what tie to put on in the morning. It used to get under my skin once in a while. Mom never told Jack what to do. Just me. I guess lots of time I kept my mouth shut just for the sake of some peace, and so Mom wouldn't freeze up the way only she could. I guess I did resent being "told" all the time, having my life planned for me, being reminded of every single thing. If that's frustration, then I was frustrated all right.

I'd take roundabout ways of escaping her watchful eye. Even ran off to get married. There was no reason to do that. We were old enough. Mom liked Mary well enough. I guess getting married was the only thing I ever managed to do on my own. No, I don't suppose all this really started with Mary, after all. Maybe I've always been this way. Yeah, I guess that's the way it is.

Why did Mom let me grow up that way? Why couldn't she see what she

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never say that out loud. He'd never come right out and stand up to her. That makes me mad, too. Why can't he? I remember the time he wanted to get me a fur scarf for graduation. Mother said I was too young and that it would cost too much. Besides, she said, I never took care of anything, anyway. So Ginny got the fur scarf when it came time for her to graduate. What did I get? A dresser set I didn't like.

I never can tell when I can depend on Dad. In spite of the nice things he does for me somehow I'm never sure that he'll be there when I need him. I'm always afraid he'll back down and do what Mother says. I simply can't compete with her, even in little things. She always takes the center of the floor. She even worked it so that every date I had finally came to the house to see her, not me. If she happened not to like some little thing about one of them, I might just as well say goodbye. He'd be frozen out. I never learned to compete with Mother and I've never been able to compete with any other women either.

Around men the best I can do is to put on the nonchalant air—act superior or hard to get—anything to throw them off. Yet I want them to like me. How can I be feminine when I know I'll run the risk of being hurt? If anyone's going to do the hurting, it's going to be me. I've been at the receiving end too long. To be feminine is to be vulnerable. That's what I can't forgive my mother—not helping me to be a real woman. Why couldn't she have cuddled me like the others when I was little? If she had ever taken a good look she could have seen how much I wanted just a little show of affection from her. I once heard her tell Aunt Nellie that I had always been a "cold" baby who didn't like to be touched. I don't believe she ever wanted to touch me.

I think of the ways I used to try to get her attention. I tried to be a tomboy, so I could compete with Billy, but she punished me for it. She thought everything he did was cute, but she only shamed me when I tried to imitate him. When Ginny came and I tried to act like her, Mother made fun of me by saying "trying to act like a baby at your age." (I was only four). It was almost as if I didn't belong to the family. I don't belong now, that's for sure.

I've found something that makes me feel as if I do belong, though, and that's a few stiff drinks. That's a good one—getting from a bottle what I've always wanted from my mother. Would she be horrified if she ever took in that idea? It's funny, but I'm not laughing. I'm crying for all the years, all the foolish, ugly ways I've tried to seek love. I'm crying for all the hateful and revengeful feelings that have scattered me this way and that, like a shell-burst of shrapnel, hurting and crippling because I've been hurt and crippled.

A woman isn't meant for hurting. There's supposed to be healing in her hands, gentleness in her touch. How can I be a woman, a real woman, a loving and lovable woman? How can I give peace unless I first find it for myself? What is that prayer of St. Francis that I've heard at AA? "Lord make me an instrument of Thy peace . . . Not so much to be loved as to love . . . Not so much to be forgiven as to forgive." Is that it? Forgive Mother? For what? Forgive Dad? For what? For not knowing, for not understanding? Who does know and who understands? I certainly don't. Poor Mom and Dad. I'm sure

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If there is to be prevention of alcohol problems and emotional ill-health, the primary responsibility lies with our parents and our teachers. A social scientist discusses

THE TEACHER'S ROLE IN THE PREVENTION OF ALCOHOLISM

BY NORBERT L. KELLY, Ph.D.

A FEW years ago one of the outstanding authorities on child guidance in America, Dr. Lawrence K. Frank, emphasized the role of the school in the development of mental health in our young. In *Society Is The Patient,* Dr. Frank wrote:

"If there is to be any preventive medicine or health care and any mental hygiene, the primary responsibility rests, not upon the physicians and psychiatrists, but upon the family and the schools, beginning with nursery schools."

He said further, and succinctly: "The mental health of the child is in the hands of the adults who are responsible for his rearing."

It is evident then, if we are ever going to prevent alcohol problems, which are basically mental health problems, we must look first to parent-child relationships. Then to pupil-teacher relationships. Our concern here is with the latter.

Alcoholism is a complex, many-faceted problem. There is no simple, easy solution to it. It can't be eliminated overnight. The attack upon it must be many-sided. I believe the teacher can play an important role in this attack to reduce and finally to eliminate alcoholism from our society. Let me now indicate some of the ways I believe the classroom teacher can help in the prevention of alcoholism and other problems of emotional ill-health.

Points Outlined

I'm going to outline my points first, then come back and elaborate on each briefly.

I believe the teacher can help prevent alcohol problems:

1. By knowing the principles of good mental health, and keeping mentally healthy herself.

2. By knowing her pupils individually, and helping each to meet his basic human needs.

3. By knowing her culture, her

society, and the demands they put upon every American adult, and helping her pupils develop the personality traits to meet these demands.

4. By being able to detect incipient personality maladjustment in her pupils, and referring these emotionally maladjusted children to properly qualified medical and psychiatric help.

5. By periodically and critically examining her school organization as it may be related to the emotional health of her pupils, and eliminating methods and techniques not conducive to emotional health.

6. By knowing and teaching the objective, scientific facts about alcohol, alcoholism, and other alcohol problems.

Need For Healthy Teachers

Now, let's go back to my first point: *the importance of the teacher's own mental health.* The teacher should know and never forget that certain forms of maladjustment are communicative. They can be communicated from one person to another—from parents to child, from teacher to pupil. Anxieties, unrealistic fears, worries, hostilities, confusion and indecision fall into this classification. The teacher who continually manifests any of these traits in her classroom engenders an emotional climate that may be conducive to their development in her students. A few years ago the National Education Association reported that approximately 20% of our teaching force, because of minor emotional difficulties, could very well avail themselves of psychological help. Given the wide incidence of emotional ill-health in American society, it is not surprising that a percentage of our teachers reflect national tendencies. Only if she is happy and healthy herself, both physically and mentally, can the teacher help guide her students to happiness and health.

Teachers Book-Loan Kit

A kit of authentic reference works on alcohol problems is available to N. C. teachers and includes the following titles.

Alcohol and Social Responsibility
Teen-Agers and Alcohol
Alcohol and Human Affairs
Manual of Reference for Alcohol Education
Facts About Alcohol
Teaching Guide for N. C. Teachers

Order from the Education Director, NCARP, 15 W. Jones St., Raleigh.

Turning to our second point, we believe that the teacher can aid in the prevention of alcohol problems and assist in the reduction of personality maladjustment by *helping her students meet their basic human needs.*

Among those working in the behavioral sciences today, it has become almost axiomatic that the most important condition motivating emotional maladjustment is the failure to satisfy basic needs. I feel it is unnecessary to amplify for our readers the fact that we all have certain emotional needs, wishes, desires, drives—whatever you wish to call them—which, if not fulfilled, may lead to profound feelings of frustration, anxiety, worry, or any of a number of other symptoms of unhealthy personality. It is imperative, therefore, that teachers know and recognize these basic needs in their pupils and help them in every possible way to satisfy them. Sometimes these needs are not met in the home life of the student. Then it is all the more imperative that the teacher fill this void whenever she can. The child who is rejected at home may find compensation in the affection and warmth of an understanding teacher. We must

remember that: "The mental health of the child is in the hands of the adults who are responsible for his rearing."

For many hours of the day this responsibility lies in the hands of the teacher. She is, in fact, a parental surrogate, a classroom parent.

My third point in discussing the relationship of the school to the prevention of alcohol and emotional health problems was that teachers could do much in this area by *knowing the demands American society puts upon all adults and helping her pupils develop social maturity.*

We must remember that modern American society is still highly individualistic. It demands that the individual "be on his own" to a marked extent. As an adult, he must be able to care for himself, to bear responsibility, make his own decisions. As an adult, he must stand on his own two feet, face up to his personal problems and solve them. No one is going to solve them for him. If he has not learned to face and solve his own problems, if he finds himself frustrated by his own indecision, he may well attempt to escape his frustration through some escape agent such as beverage alcohol. The latter, as you will remember, is an anesthetic and has the numbing power to help one run away from frustration.

Teachers, therefore, should help and guide their students in developing the characteristics of the socially mature person, the person who does not need to escape from life's realities. Any aid in helping the young develop independence of action and thought; helping them to learn to assume responsibilities; any encouragement that will help them to be at ease in groups; any guidance that will help them learn decision-making and problem-solving; any counsel that will lead them to see the very great value of the Golden Mean as well as the Golden Rule will be a wonderful contribution toward their social adjustment and personal stability as adults. Adjustment and stability are not conducive to participation in alcohol problems.

An invaluable service in combatting alcohol and personality problems may be rendered by the teacher *by detecting incipient personality maladjustment among her students and referring such children to qualified medical help.*

This means, of course, that each teacher must have an adequate knowledge of both child psychology and abnormal psychology. They must know and be able to recognize the symptoms of incipient maladjustment when they are manifested in child behavior. They must be capable of realizing the significance of such mechanisms as overconforming, submissiveness, and dependence, as well as hostility and rebelliousness. They must be able to evaluate the importance of such manifestations as tics, obesity, asthma, hives, frequent accidents and frequent colds.

More than this, even before such symptoms of incipient ill-health develop, knowing and perceptive teachers can be on the lookout for the environmental influences that may

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Audio-Visual Aids

The following films are recommended as aids in classroom discussion of alcohol problems.

What About Drinking
What About Alcoholism
Alcohol and the Human Body
Alcoholism
None for the Road
Kid Brother

Write the State Health Department Film Library.

Parents must aid children in developing durable personalities, resistant to the stresses so prevalent during young adulthood.

IMMUNITY FOR THE TENSION YEARS

BY GEORGE ADAMS

THE "Tension Years" of young adulthood is a period when individuals are particularly susceptible to emotional illnesses like alcoholism. This is the time when young people leave the protected environment of parental homes, schools and colleges to take on adult responsibilities.

One important reason for the high occurrence of alcoholism among young adults is that there is such a wide gap in our social structure between youth and adulthood. The adolescent is protected and indulged, allowed to be carefree and irresponsible. Yet, there comes a day—perhaps marked by college graduation or a twenty-first birthday—that the same young person is expected to emerge from his protective cocoon, a full-fledged adult, ready to meet life head-on.

The problem is, that many persons never *learn* how to be adults. As a result, when confronted with adult problems, they feel inadequate to cope with them. They, in turn, build up anxiety, tensions, stress which demand release. Excessive drinking may be indulged in to release these pressures and "escape" new problems.

Others weather the storms of young adulthood, little the worse for wear. They accept their responsibilities easily and confidently. If tensions build up over life's little irritations, constructive channels are found for their release. These young adults are emotionally mature individuals. In the process of growth from infancy, they *learned* maturity in slow stages. They are not likely to need the artificial courage and confidence found in a bottle of beverage alcohol.

The institution in our society whose task it is to teach maturity is the *family*. If it does its job well, its children will be healthy and resistant to emotional stress. If the family does not do its job well, its product is likely to be susceptible to the stress

illnesses, like alcoholism.

The young adult of today is a reflection of a countless succession of attitudes, feelings, reactions and behaviors learned in the family during the early years of growth. The foundations of emotional maturity, then, are laid by *parents*. Immunity from the stresses and strains of the young adult years is a responsibility of parents—present and future.

A greater part of that awesome responsibility would be relieved if it were possible to have all babies vaccinated with an "anti-mental illness" serum during the first few months of life. Then there would be nothing to worry about. An appealing thought, but no such vaccination is available. Recall that emotional health is a result of a *long succession of learning experiences*. No single shot immunity will work the trick.

But, we suggest that it is still possible for parents to immunize children, to a greater or lesser degree, against emotional ill health. Suppose, for example, that we analyzed young adult life, trying to determine the chief points of potential emotional stress. Then, suppose we decide to expose our children to small doses of these troublesome factors while they are still under our protection and care. That's logical, isn't it? Then the adjustments of adulthood don't come as such a shock, because they have been experienced before.

This is an immunization process, too. Admittedly, it is a much slower process than that administered with a needle and syringe. But behavior scientists believe that it can be just as effective.

Personality Requirements

Look, for example, at an average young adult male today. What qualities of personality does our complex, highly developed American society require of him?

Begin with *decisiveness*. The young

adult is expected to make sound decisions with a minimum of delay and "stewing".

He must be willing and able to assume *responsibility* easily and confidently. He has a family to support, a career to advance, community obligations to fulfill, etc.

Initiative is another vital attribute for successful adult living. The adult is expected to have enough "get up and go" to strike out in uncharted directions and to carry enterprises through to successful completion.

He should possess a high degree of *self-confidence,* based on a feeling of personal adequacy and worth.

Our modern age is characterized by constant and rapid change and uncertainty. In order to adjust to these conditions, the individual should have a reserve of *flexibility* and *equanimity.*

Life's Demands

Decisiveness, responsibility, initiative, self-confidence, flexibility, equanimity, are all necessary traits for successful adult living. Lacking some or all of them, the young adult may find life's demands more than he can bear.

To help children develop these traits is one of the most challenging jobs facing parents. It is not an easy task. There is no guarantee that possession will ensure immunity against emotional illness. But as far as we know, they greatly increase the possessor's chances of avoiding it.

In order to help children develop these needed traits, parents must be prepared for some jolts to their own egos. Under this program, children are allowed to grow steadily in independence, gradually slipping out of parents' protective grasp. Children are left to work out their own small problems, make some of their own decisions, and to bear their share of the family's work. Parents can no longer pose as all-wise, all-knowing saints directing childrens' lives and handing down edicts from their lofty places. Children must be permitted to make their own mistakes, without benefit of parental warning, to be hurt by those mistakes and encouraged to go back and try again.

Practice Adulthood

To put it simply, children must *practice* being adults if they are to be ready for adulthood. But immunizing doses of experience should aways be administered with an eye to the child's total personality needs. To concentrate solely on developing responsibility and initiative, for example, without recognizing the accompanying need for affection, encouragement and guidance would be to neglect some of the child's basic needs.

Behavior scientists tell us that the basic needs of human beings can be

ON AUTHORITY

AUTHORITY is another common factor which relates living people to one another. Someone gives orders to most of us. Most of us hold authority over some one. Violent resentment toward all authority or insatiable appetite for the exercise of authority over helpless dependents can make life with other people a most unhappy experience.

From THE SUBSTANCE OF MENTAL HEALTH by George H. Preston, M.D.

reduced to these: (1) the need for a feeling of personal security; (2) the need to have one's self recognized, esteemed and valued; and, (3) the need for a variety of new experiences to add zest to life.

Human Needs

The feeling of *personal security* arises partly from having one's physical needs adequately provided for. Everyone needs adequate food, drink, clothing, shelter and protection from danger. Equally important is the need for *emotional security*. Parents who successfully foster emotional security are those who have found a "middle way" between domination of children on the one hand and over-indulgence on the other. To feel secure, children must be granted increasing independence as they grow in maturity. It is only in this way that they can develop the required adult personality traits already discussed. At the same time, the wise parent will not cultivate independence to the exclusion of discipline and rules of behavior. The child must learn that society has rules and regulations which cannot be flouted, even under the banner of "independence" and "freedom". The end product of this middle course in parent-child relation when administered with generous amounts of affection, praise and mature guidance is likely to be a secure adult, confident of his own worth and able to meet the frustrations and stresses of adult life.

The second need, that of *recognition* and *esteem,* is nowhere more obviously expressed than in our highly competitive American society. To be successful in business, for example, is to be distinguished from the crowd. It brings prestige, recognition — a feeling of accomplishment and worth. Achievement rates a top spot in our American system of values.

Success Over-Emphasized

Suppose that a family over-stresses the success-achievement theme to its children. Dad, for example, decides that Johnny, age 6, is going to be a doctor and live in a big house on the hill. Johnny is never allowed to forget that he is destined for "success" as a physician. But look at Johnny's side of it for a minute. Maybe Johnny doesn't want to be a doctor. Perhaps he would be much happier as a landscape architect or a dairy farmer. But Johnny doesn't have much say-so in the matter. Dad has already decided for him.

Or, look at it another way. Suppose Johnny doesn't have the native ability and aptitudes for medicine. Either way, he will be a misfit and will probably fail to live up to his Dad's expectations. He will always carry the gnawing feeling that he has fallen short of the mark. Many young

ON HATE

HATE we must also learn to handle. Hate is a normal human emotion and yet man's customs in regard to hate are extraordinarily inconsistent. You must "love thy neighbor as thyself" and yet "neighbor" must be so defined that when you go to war you can hate and kill. Little children say, "I hate you," and are promptly told they are wicked. The fact is that for the moment they do hate and had better learn what to do about it.

From THE SUBSTANCE OF MENTAL HEALTH by George H. Preston, M.D.

adults become alcoholics trying to blot out these intense feelings of failure fostered through unwise parental emphasis on success.

Parents, then, may be sowing the seeds of later maladjustment when they play the "success" theme too strongly. Instead they should help children to achievements within the limits of their abilities and motivations, being quick to lend praise and encouragement to all the child's efforts and accomplishments. Children should feel that parents value them for what they are, not for what they might be.

New Experiences

The final need of human beings is one that we express, perhaps unconsciously, almost everyday. "If I could just get out of the old rut," you say. Or, "Gee, I need to get away." "I'm sick of the old routine." These are expressions of a universal need—for new experiences to add zest to life.

It is one of the important duties of the family not only to supply adequate amounts of new experience but to stimulate its younger members to pursue this need through developing creative interests of their own.

With our intense need for escape—for something to give us a new outlook and taste for life, it is unfortunate that most of us fail to find constructive escapes. Our recreation consists of watching somebody else do something—on television, on the playing field, at the movies. We end up just as bored with our recreational activity as we are with the daily routine we are trying to break. Drinking is another way to escape boredom. Case histories of alcoholics reveal that drinking becomes for many of these unfortunate people literally their *only* recreation and avocation.

To help fill the need for creative new experiences, we suggest that parents cultivate the pursuit of some interesting hobby activity by each and every family member. The hobby may be gardening, clay modeling, painting, carpentry, rock collecting, rug making, or any one of a thousand other choices. Each child should be informed of the wide range of choice and then subtly encouraged to choose one or more avocations to fit his interests. Hobbies, avidly pursued, bring rich rewards in new experiences. More than that, they allow some people to achieve a share of the recognition and approval which they may have missed in their business or professional lives.

Mental Health Program

There, in brief, is a suggested mental health program for application by parents. Summarizing, it calls first for giving children controlled, immunizing doses of adult experiences; particularly emphasizing the development of decisiveness, initiative, responsibility, self-confidence, flexibility and equanimity. The plan should recognize and adequately meet the child's basic needs—(1) for security, (2) for recognition, (3) for new experience. Sprinkle liberally with love, affection, praise and consistency. Expect no miracles to be accomplished by such a program. But if consistently applied, the end product should be an adult capable of living a happier, more useful life, less susceptible to alcoholism and the other stress illnesses so prevalent during the "Tension Years."

Books of Interest

TEEN-AGERS & ALCOHOL

A Handbook for the Educator
By Raymond G. McCarthy
New Haven: Yale Center of Alcohol Studies

"MOST Americans have implicit faith in their schools; they believe the solution to social problems depends on good education." *Teenagers and Alcohol* has many practical suggestions for educators in planning programs about the social problems involving the use of alcohol.

The author has developed this guide after many years of experience in The Center of Alcohol Studies at Yale, and with teachers and education leaders in most of the states. No specific plan is advanced in this publication. Rather many suggestions are listed to help local leaders, working with all others concerned in the community, to evolve a working plan that will include some instruction about alcohol in the school program.

Part I.

This section of the book includes discussions about the need for "Developing a Working Philosophy." The author calls attention to some of the problems schools encounter in determining their responsibilities relative to social problems, particularly those involving the use of alcohol. Four outlines of a working philosophy for instruction about alcohol are included as examples of what many modern schools are doing.

Until recent years, the author points out, education about alcohol was largely about the physiological effects of alcohol on the human body. Since 1945, questions about drinking and the prevention of alcohol have received attention.

The concept of alcohol instruction as a narrow segment of subject matter readily disposed of is no longer appropriate, says our author. He notes that there emerges instead a philosophy of teaching concerned with the child and his problems of adjustment during his growing to adulthood.

Reference is made in this publication to information revealed in studies about the drinking practices of high school and college students. These can remind educators of the need to review carefully their responsibilities for teaching about alcohol.

There is a body of information about alcohol on which there is little disagreement says the author. The chemical nature of alcohol, its action in the body, and something of the way the body reacts can be determined in the laboratory. But he also includes discussions about the many and varied opinions and some of the misconceptions about the consumption of alcohol, advertising, moral issues, the economics of the problem, and the relation of drinking to juvenile delinquency. He goes on to point out some of the arguments presented by those taking sides on these issues.

This first section closes with a discussion on alcoholism and some

of the causative factors.

Part II.

"Organization and Techniques of Instruction" used by modern educators is the general topic for the second section.

Most teachers agree, says Dr. McCarthy, that alcohol education should be a part of general education. Because it cuts across many subject fields, it needs the integrated approach. Also pupil growth in social understanding cannot be identified with any particular subject experience.

According to information given in this book, manuals from several state departments indicate that good alcohol education is primarily good general education.

The author points out the controversy over grade placement for instruction about alcohol and the changes taking place at present. In earlier days the greatest emphasis was in elementary grades. Now the general opinion is that teaching in lower grades should be about good eating and drinking habits.

The author has included a very helpful section on the "Discussion Technique Versus the Authoritarian Approach to Learning." He goes on to show that pupils need experience in making decisions and taking responsibility for them within limits if they are to have these necessary skills when they are adults. Various group methods are discussed and some values of each noted.

The author calls attention to the fact that the school needs "to adopt a policy on the teaching of controversial topics and to interpret it to the community as well as to the faculty."

Part III.

Included in this section are some very interesting "Transcribed Class Discussions About Alcohol." Two of these are based on material in the Science Research Pamphlet, *Facts About Alcohol.* The script from the film, "What About Drinking," is included. Four transcribed class discussions following the viewing of the film, "What About Drinking," conclude this section.

The recordings for these transscriptions were made in high school and college classes in social studies, ethics, teacher training, and grades 10 and 12. In making these the author says they are seeking answers to these questions:

1. Will young people speak freely of their attitudes about alcohol?
2. Will discussion progress without getting out of hand or becoming irrelevant?
3. Can teachers use to advantage material which develops during discussion sessions?

Class discussions will not necessarily lead to solutions to all problems but it certainly can condition young people to an approach to questions about the problem of subject, says the author. "Flexibility, critical evaluation, suspended judgments, and avoidance of unfounded generalizations are valuable attitudes of mind in analyzing any complex situation. They are particularly appropriate and necessary in dealing with questions about alcohol."

The appendix includes student opinions, teacher reports and student responses to the film, "What About Drinking," and a list of selected refences.

The fact that this publication is already in its second printing is evidence of its popularity and usefulness.

—Annie Ray Moore
Health Educator
School Health and
Physical Education Dept.
N. C. Dept. of Public Instruction

The Teacher's Role

(Continued from page 23)

eventuate in their appearance. Knowing the homes from which her students come, being acquainted with parental attitudes and the relationships between parents and children may forewarn the teacher of possible personality developments among her pupils.

If such developments do take place, the teacher should be thoroughly acquainted with the procedure in her school for seeing that the child gets the medical and psychiatric aid he needs. The earlier personality deviancy is diagnosed and treated the easier it is to bring it under control.

Classroom Analysis

My fifth point concerning the relationship of teachers to alcohol and emotional problems stressed *a periodic examination of the school's structure and function as they are related to pupil needs and emotional health.*

There are certain features found in many educational systems that are a cause of concern to many people interested in mental health. Educators are even more familiar with these conditions than I am. So I'm going to content myself here simply by raising a few questions that I think the classroom teacher should be asking herself. Here they are:

1. Is the amount of homework I give conducive to my students' full participation in an enriching home life?
2. Are the reporting and promotion systems consonant with good mental health development?
3. Is authoritarianism or democracy the underlying climate in my classroom?
4. Am I guilty of promoting classroom monotony and boredom?
5. Do we have adequate psychological testing services in our school?
6. Is there need for psychiatric social workers in our education system?
7. Does each of my students have access to skilled vocational guidance?
8. Are my students being prepared for marriage and wholesome family living?

These are some of the questions I believe I would be asking myself were I a classroom teacher and vitally interested in my pupils' emotional development.

The final way in which teachers may assist in the reduction of alcohol problems is *by knowing and teaching the objective facts about alcohol and alcohol problems.*

Some seventy million adult Americans use beverage alcohol in one degree or another. I surmise that most began drinking without knowing very much about the anesthetic they were ingesting. I believe our boys and girls have a right to know what alcohol is and how it acts on the central nervous system before they are called upon to make a choice concerning its use. You know and I know how widespread drinking customs are in America. Each and every young person at some stage in his development is going to have to choose one way or another. I believe they should be adequately prepared to make a choice.

In North Carolina when alcohol education is taught by adequately prepared teachers who have an objective viewpoint it has proved a most interesting subject for junior and senior high school students. They not only need such instruction, we have found they want it.

I'm going to summarize what I've been saying about the role of the teacher in the prevention of alcohol

problems by again directing a series of brief questions to them. As I close, I ask our teachers:

1. Do you know yourself? Are you emotionally healthy?

2. Do you really know this society in which you live? Do you understand the specific demands it makes upon each of us?

3. Are you thoroughly acquainted with the basic strivings of all human beings? Do you help your students attain these needs and strivings?

4. Are you treating your students as individual human beings? Do you recognize changes that come over your students that token madadjustment? Do you know your students this well? Do you know their families?

5. Do you accept your school as it is? Can it be improved so that children may more easily grow into socially mature, confident, self-reliant, happy and healthy adults, capable of meeting the continuing challenges of our American way of life?

6. Are you providing them with adequate knowledge to combat alcohol problems? They want it. They'll thank you for it. If you provide it, I think that you as teachers, will be making a marked contribution towards the prevention of alcohol problems.

A Woman Speaks

(Continued from page 19)

they did the best they could by us children. They probably thought giving me the dresser set and Ginny the fur scarf was right and fair. How can I blame them for not understanding me when I hardly understand myself. And at times I know I wasn't the easiest person to get along with either.

Is everyone in the dark when it comes to seeing himself and his effect on others? One thing I begin to see—myself. I see the years I acted like the hurt child I was so long ago, striking out at everyone, especially my parents. But hurting myself worst of all.

Can I grow up at this late date? Can I change, even a little? Let me begin with forgiveness. Will you help me, Doctor?

A Man Speaks

(Continued from page 18)

was doing to me? For that matter, why could Dad or Jack see what they were dong? Or the office crowd, the boss, or Mary?

I want to take my own responsibility. Want to give love, real love. I don't want to bargain for it. I want to be all the things Mom wouldn't let . . . no . . . I want to be all the things *I.* think I ought to be—not what somebody else thinks I ought to be. I don't want to be afraid that way any more. That sounds better already. Now, how can I love myself unless I clear up this feeling toward Mom? Perhaps I've misunderstood a lot of things about her and about myself, like her not letting me go. Maybe we both held on too hard for the same reasons. The Doc says everyone has to learn how much to hold on and how much to let go because everyone is different.

Perhaps Mom had her own problems, too. Maybe her mother and father did things to her when she was little just as she did things to me. Or maybe things didn't work out for her in her life the way she had planned, and having us children to raise and care for just made it worse.

It must be tough, being a parent. Maybe it's as tough as being a son. Well, I seem to be making progress. Maybe at last I'm on the right track.

Forgive you, Mom? Mom, I'm getting to be a big boy. Mom, I love you.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

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North Carolina Library

NOV.-DEC., 1957

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Pastoral Counseling Of Alcoholics

How To Keep From Becoming A Problem Drinker

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Hope For the Woman Alcoholic

No Wassail For Santa—A Short Story

How Group Therapy Helped Me

Personality Sketch—Dr. Macdonald

Book Review

Program Pointers

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

VOLUME VII NUMBER 4

NOVEMBER-DECEMBER, 1957

RALEIGH, N. C.

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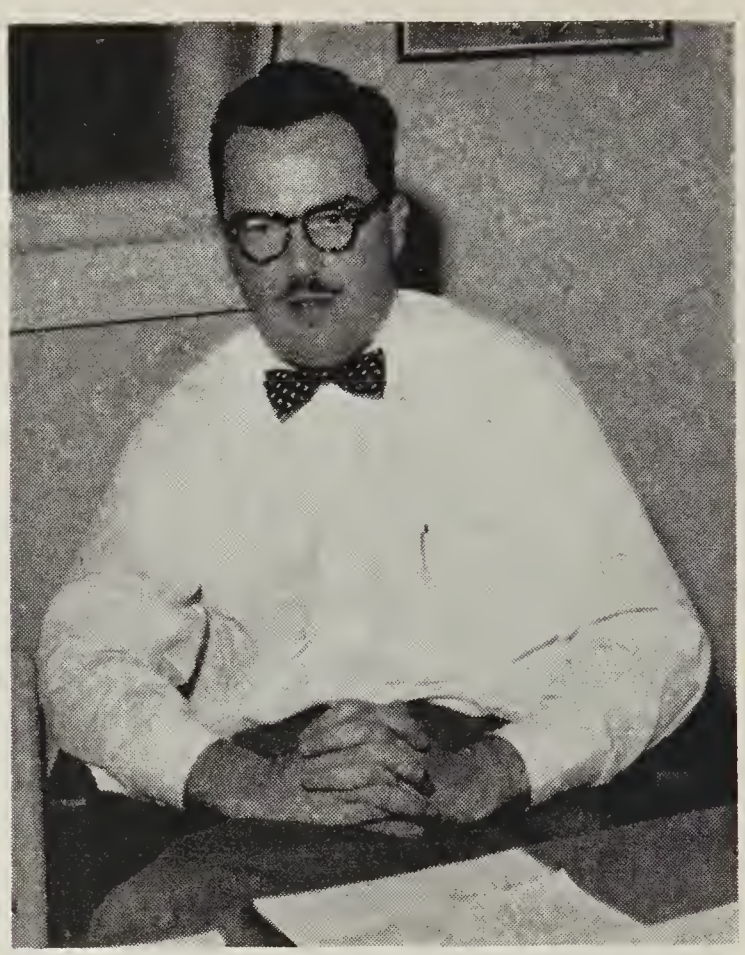
Personality Sketches



DONALD MACDONALD, M.D.

Clinical Director
Butner State Hospital,
Alcoholic Rehabilitation Center

NUMBER 13 is the lucky, not unlucky, number for Dr. Donald Ewen Macdonald, new Clinical Director of the Alcoholic Rehabilitation Center and the State Hospital at Butner. With 13 doctors in his family to influence him, what chance did Dr. Macdonald have to become anything other than a doctor himself? And on that lucky day when the young Scotsman from Dundee made up his mind to go into medicine, little did he realize how lucky, too, would be the Alcoholic Rehabilitation Center, located in a remote place called Butner, North Carolina.

Leaning back in his chair, Dr. Macdonald appeared relaxed and at ease when we interviewed him in his office. A tall, stockily-built young man with piercing eyes and a mustache distinguishing his face, Dr. Macdonald told of his birthplace, Dundee; of his childhood desire to become a doctor, and of the St. Andrews Medical School in Dundee, from which he received a M.B.Ch.B degree in 1948 (equivalent to our M.D. degree). A slight Scottish brogue lent charm to his speech. On the wall across from his desk hung a map of Scotland divided into clans and their tartans.

As one of the two Clinical Directors of the Butner State Hospital, Dr. Macdonald shares the responsibility of looking after its 1700 patients with Dr. Desmond McNelis. And for an Irishman and a Scotsman, they work together very well.

New Ideas For The Center

Dr. Macdonald is also Clinical Director at the ARC, and he devotes a good portion of his time with the Center and its patients. He loves working with alcoholics and has a number of new ideas for the treatment program. With the difficulty alcoholics experience in solving reality problems current in their lives, Dr. Macdonald believes more emphasis should be placed on supportive therapy, rather than on uncovering past experiences in the patient's life. In the 28 days a patient stays at the Center, Dr. Macdonald feels neither the therapist nor the patient would

(Continued on page 28)

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH: A "Get-Together" Breakfast for the alumni of the Alcoholic Treatment Center at Butner, N. C., was held November 2 at the S & W Cafeteria. Attending were over 35 alumni, plus several speakers. Dr. Norbert Kelly, George Adams and Miss Roberta Lytle represented the NCARP at the breakfast. Our congratulations to Rosemary D., and many others who worked so hard to organize this reunion. Many other groups might be interested in setting up a meeting of this kind. If so, write the ARP office and we'll be glad to give you our help.

NEW YORK STATE: A regular course for social workers dealing with alcoholics is now being offered in the School of Social Service at Fordham University. The lecture covers legal, moral and medical aspects of alcoholism; the woman alcoholic, and the extent of the problem in the United States. Taking the course are case workers, court personnel, welfare agency and probation officers as well as students working for degrees.

NORTH CAROLINA: A Pastoral Seminar on Problem Drinking and Alcoholism was held October 28, at the First Presbyterian Church in Lenoir, N. C. The theme of the Seminar was the Role of Religious Bodies in the Treatment of Inebriety. Dr. Norbert Kelley, Education Director of the ARP, attended.

NEW ZEALAND: The National Society on Alcoholism, New Zealand, reports that a postgraduate course on alcoholism was offered during the summer to general practitioners and others in the medical profession. Results: A definite increase in well-informed and cooperative family physicians in the community.

RALEIGH: A good idea now being effected by the Edenton Street Methodist Church in Raleigh is alcoholic counseling for alcoholics and their families, conducted by a member of Alcoholics Anonymous. Appointments for counseling services are made through the Pastor. The ARP wonders if other churches in the United States are using alcoholic counseling as part of their program and if so, would like to hear of their progress.

AVON PARK: Warren B. Parks, Jr., has been appointed Educational Director of the Florida Alcoholic Rehabilitation Program. Mr. Parks was formerly an instructor of sociology at the University of Florida.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

ONE of the nicest things to happen to us in a long time was the Get-Together Breakfast held on November 2 at the S & W Cafeteria in Raleigh, by the ex-patients of the Alcoholic Rehabilitation Center at Butner. The breakfast was entirely the ex-patients' idea and was sponsored and organized by them alone. We of the ARP staff received a great deal of pleasure from the breakfast and were glad to offer the little help we did in the mailing of invitations.

We hope this "reunion" idea will be picked up by ex-Butner patients in other areas of the State and any group which would like to plan a similar meeting can count on support and assistance from the Raleigh office of the ARP.

New Clinical Director

We are delighted to welcome to the ARP family Dr. Donald E. Macdonald, Clinical Director of the ARC. A personality sketch of Dr. Macdonald appears on page 2 of INVENTORY.

Several years ago we had prepared for us an exhibit for use at the State and County Fairs and at other public and professional meetings. This exhibit has been used consistently through these years with only one refurbishing. After so long a time, we felt that perhaps this particular exhibit had lived its life of usefulness. But due to limitations in funds, we were unable to solicit the assistance of professional exhibit designers and builders.

The need for a new exhibit containing new messages was so enthusiastically felt by members of our staff that we decided to make our own exhibit. This we did, including our own designing, building, painting, decorating and assembling. Accordingly we completed the exhibit in time (no thanks to Asian flu, though) for the 1957 State Fair in Raleigh.

We now have a display of which we can truly and justifiably be proud and one which has received a good deal of favorable comment.

When our bills were all assembled and costs calculated, we found we had spent $162.71. This included all nails, lumber, pegboard, screws, paint, brushes, art work, lettering, photographs and lighting. This amount is less than the freight paid by the organization whose display was next to ours in the exhibit hall, and who also was concerned with a national health problem. And best of all, the exhibit belongs to us and can be used time and time again on other occasions.

We have begun something new at the ARP. The middle of November we prepared and mailed out public service announcements to every radio station in the State, 119 in all. The spots give information about alcoholism and the Treatment Center at

(Continued on page 29)

VOL. VII, No. 4 INVENTORY NOVEMBER-DECEMBER, 1957

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

HOW GROUP THERAPY HELPED ME

As a recovered alcoholic, I am often asked what helped me most. My answer: group psychotherapy.

THREE years ago, I was a patient at the North Carolina Alcoholic Rehabilitation Center at Butner, and it is my opinion that a patient more confused than I was never entered Butner for treatment.

Here each patient is given a final interview with a psychiatrist to sum up the highlights of the patient's reasons for drinking. This interview was only a slight beginning to understand my drinking and confusion. At the time of my final interview, the importance of follow-up treatment through a Mental Hygiene Clinic was stressed to me.

With the great emotional stress which I was undergoing, I decided to try psychiatric treatment as a last resort, and it was also my decision to follow through with this treatment. I had started many kinds of therapy to help my drinking problem, and with each I would feel better and cease to go for further treatment. Then the rat race would start again, and I would seek "another cure".

Upon my release from Butner, I immediately wrote for an appointment to begin psychotherapy. The clinic to which I wrote was just beginning and there weren't enough patients to begin a group at once. As a result of this, I received individual therapy for about three months.

Finally the doctor told me that the

following week I would meet with the group for my first group psychotherapy. I was quite skeptical of this due to being afraid that I would not be able to express my feelings with others present, afraid that I wouldn't like the other members, and afraid of what the group might feel toward me. Along with the fears there were also apprehension and anticipation as this was a very new experience for me.

The first few meetings were a bit uncomfortable as we in the group didn't know each other and we were afraid of our reactions to each other. As time when along, we became more at ease and were able to talk more without long periods of silence.

Jigsaw Puzzle

Psychotherapy reminds me of a big complicated jigsaw puzzle. At first all of the pieces are strewn about and some are upside down with no order or arrangement to them. This corresponds to the chaos and disorder of our emotions when psychotherapy is started. As one prepares to arrange the pieces in place, the goal is to have a pretty picture when the puzzle is completed. The same holds true of psychotherapy except a pretty life is desired rather than a picture.

The border pieces were quite easy to find as they had straight edges. While finding the border pieces to the puzzle, I became quite proud of my progress, because things weren't so complicated as I had once felt. Then the border was completed and I started searching for some inside pieces, which wasn't nearly so easy as the border. For several weeks, I would look for one piece, and finally it was found. After slowly finding each piece, I felt I had passed another milestone and was ready to look for more pieces. Each piece which is located and put into its place brings me nearer to my goal of a serene and satisfying life.

During the time I have been going for group psychotherapy, I have been associated with several group members. Some go only once and quit and some go several times and drop out. There are some who have attended regularly since their first meeting and some who attend irregularly. Some of us continue to drink once in a while, and some have remained sober since attending the first time.

The people who attend only one or a few meetings usually say that they receive no benefit from group psychotherapy. The group members who have attended regularly for a period of time usually always say that this type therapy helps them a great deal. These are the ones who continue to come for further help and understanding of their problem.

A psychiatrist always attends with our group, and his contribution to our discussion is very helpful. He never gives us direct answers, but his comments and questions sometimes guide our line of thought. It is sometimes through his pertinent questions that we start to think about our subconscious feelings which cause so much emotional distress. With enough thought and discussion about these things which are very complicated and baffling, we usually discover our true feelings. When these feelings become conscious rather than subconscious, they are no longer complicated and baffling.

I have now had group psychotherapy for almost three years and I continue to have many unanswered questions and unsolved problems. It is still my decision to follow through until all of the questions have been answered and all of the problems are solved to my own satisfaction.

If I were asked to name the one thing which has been most helpful to me, my answer would have to be "Group Psychotherapy."—*Miss A. L.*

PASTORAL COUNSELING OF ALCOHOLICS

Like it or not, the minister must deal with alcoholics and their families. Here are tips on how to do it constructively.

Copyright 1957 by Journal of Studies on Alcohol, Inc., New Haven, Connecticut.

WHILE "teams of scientists are devoting their skill to the problem of helping alcoholics, and Alcoholics Anonymous has achieved such impressive success in leading thousands to sobriety the pastor examines his own meager success in the field and wonders whether he should leave such work to the scientists and to AA. Is there a real need any longer for him to be active and informed concerning alcoholism? Can he expect to be reasonably effective if he is?"

These questions are asked by H. J. Clinebell in his recent book on understanding and counseling the alcoholic. One of the greatest needs of the clergy, he feels, is a definition of their role in this area and how they can function most effectively. For whether they like it or not, they will have to deal with problem drinkers and

their families. The question is how to do it in a constructive way.

A survey conducted by the Yale Center of Alcohol Studies in cooperation with the National Council of Churches revealed that some 50,000 alcoholics are seen in a year by American ministers. In many cases the clergyman is the first person called for help. Whether he handles this opportunity well is, consequently, of signal importance. The feeling expressed by some AA members that only an alcoholic can help another alcoholic has caused some pastors to question their own ability in this field. No doubt the minister is at a disadvantage in some respects. But he also has certain unique advantages. These include his natural and easy entree to the family, the confidential nature of the relationship, and the absence of fees.

Attitude Important

According to Clinebell, a pastor's general attitude toward drinking has much to do with whether he discovers the problem drinkers whom he may be able to help. If he is known as a militant prohibitionist or total abstinence advocate, alcoholics are not likely to seek him out. If he has only projected an unctuous, moralistic quality, he still will be bypassed by most. In short, the pastor's personality, and how he relates to his people in every sense, are important in determining whether those in trouble, including alcoholics, are drawn to him for counsel.

The pastor can wait for problem drinkers to come to him, or he can play a less passive role. In Clinebell's experience, the most productive method is to deal with alcoholism in a sermon or public talk, treating the subject in a non-moralistic manner. "Personally, I have had more opportunities which have come as a result of such sermons than from any other sources."

Once the opportunity has been won, what are the goals of counseling with alcoholics? The eventual goal is referral—bringing together the alcoholic with the therapeutic agencies which specialize in his problem. The pastor should think of himself as part of a team, always ready to relate the alcoholic to the members of the team who can do most for him. Working as an isolated counselor, the pastor "will usually have a very low rate of success with alcoholics." Cooperating with an alcoholism clinic, AA, or other available resources, he will make a much greater contribution.

Referral Resources

If the eventual goal of counseling with alcoholics is referral, this implies the existence of adequate referral resources, and that the alcoholic is ready to take advantage of them. But often the reality is different. If referral resources are not available, the clergyman as a community leader is in a strategic position to mobilize interest in providing them. If the obstacle is only that the alcoholic is not willing or able to utilize existing resources, then the pastor's function is to help him to become so, to help him to accept the fact that he has a sickness for which he needs treatment. This task often requires the arousal of a desire for sobriety. To achieve this, a counseling relationship must be established and the pastor may have to devote much time to this individual before referral is possible. In the process—especially if his efforts seem successful—he may be tempted to hold on to his counselee indefinitely. But he should remember that, unless his training and skill are exceptional, he is well-advised to avoid delving deeply into the underlying problems. Even if he can spare the time for

prolonged therapeutic counseling, he should keep in mind that the psychological conflicts of the problem drinker are seldom simple in nature. But even if there were no other considerations involved, the time element alone would be prohibitive.

Hence, most clergymen are more than willing to focus on intelligent referral, limiting their counseling efforts to the following: (1) Those individuals who need more or less extensive preparation for referral. (2) Cases in which a special religious problem exists as a block to happy sobriety. This is the minister's forte. (3) Circumstances where other resources are not available. Fortunately, this is becoming increasingly unlikely. (4) Those individuals who continue to have personality problems even after sobriety has been achieved.

To perform this task effectively, the pastor should familiarize himself with the basic scientific knowledge concerning alcoholism and its treatment. He will need to interpret the sickness to the alcoholic and his family. He should also have training in the general principles and techniques of counseling. Lastly, it would serve him well to read the literature dealing specifically with the counseling of alcoholics. For each instance, Clinebell provides concrete examples.

Naturally, the primary concern of the individual pastor is to discover what referral resources exist in his own community and to acquire firsthand knowledge of each. If there is a local clinic, AA group or alcoholism information center, they will have reliable information about such things as the practices of local hospitals with respect to accepting alcoholics, where homeless alcoholics can be satisfactorily housed, and which psychotherapists and physicians undertake the treatment of alcoholics.

If the pastor lives in a community having a local Committee on Alcoholism, he will be able to support its work in addition to receiving information and help. If no such committee exists, he can perhaps be influential in sparking the creation of one. About 100 cities in the U. S. A. and Canada now have specialized outpatient clinics for problem drinkers.

Clinebell notes that some clergymen tend too readily to refer the alcoholic elsewhere—perhaps because their efforts in the past have been fruitless. This, too, can be dangerous to the extent that the alcoholic feels it as rejection. If the minister thinks of referral as a sharing rather than shifting of responsibility, this danger will be largely eliminated.

PART II—TECHNIQUES

"The essence of counseling is the establishment of a certain quality of relationship, the relationship of acceptance. . . . Because of the anxiety, guilt, low self-esteem, and sense of isolation of the alcoholic, such a relationship is often difficult to establish," says Clinebell.

It goes without saying that a clergyman who feels any hostility toward a particular alcoholic, or toward alcoholics in general, should not try to do more than refer them to someone else. For the alcoholic will not be able to accept healing help until he realizes that he is sick. And this he cannot do unless his counselor whole-heartedly subscribes to the sickness concept of alcoholism. In accepting this concept with all of its ramifications, the pastor divorces from his mind the feeling that he is dealing with a moral deviation or a perverse habit. Only then can he avoid conveying a judgmental attitude which would bar an effective counseling relationship.

Counseling an alcoholic, says Clinebell, is basically the same as counsel-

(Continued on page 30)

Check Yourself

For These Preventive Measures

- ✓ **Be Sensible About Your Ambitions.**
- ✓ **Learn To Stand On Your Own Feet.**
- ✓ **Don't Be A Worrywart.**
- ✓ **Refuse To Pity Yourself.**
- ✓ **Shun Suspicion And Resentment.**
- ✓ **Get It Out Of Your System.**
- ✓ **Be Tolerant Of Yourself.**
- ✓ **Learn To Laugh At Yourself.**
- ✓ **Recognize The Value Of Work.**
- ✓ **Cultivate A Relaxed Attitude Toward Your Work.**
- ✓ **Have Fun.**
- ✓ **Believe In Something Bigger Than Yourself.**

Here are some key suggestions based

HOW TO KEEP FROM

From HOW TO LIVE WITHOUT LIQUOR, copyright 1955 by Ralph A. Habas, published by Farrar, Straus and Cudahy, Inc.

NOBODY ever becomes a problem drinker overnight; as a rule it takes years for alcoholism to develop. So there's generally plenty of time to spot the symptoms and arrest the disease before it gets very far along. Even after a person has crossed the borderline, something can be done about it.

But as with any ailment, the conditions which culminate in chronic and excessive drinking are most easily and effectively treated early, before the stage of actual alcoholism is reached. And here, as in other things, an ounce of prevention is worth a pound of bandages.

What, exactly, can you do in order to minimize the possibility of your ever becoming a problem drinker? How, in other words, can you go about improving your mental health, and achieving a more happy and efficient life, so there will be little or no chance of your turning to liquor to make your life livable? Here are some key suggestions based on the advice and findings of psychological and psychiatric authorities and plain common sense:

1. Be Sensible About Your Ambitions

You can be your own best friend or your own worst enemy, depending on just how you think about success. Does success, to you, mean things like making a lot of money, owning a pretentious home, holding down a big or glamorous job, belonging to swanky clubs? If these are your ambitions,

BECOMING A PROBLEM DRINKER

BY RALPH A. HABAS

then you're chasing a will-o'-the-wisp. For regardless of your actual achievements, you'll never feel that you've really gotten what you're after . . . .

Your ambitions, if you're sensible, will be merely to improve yourself and better your position within realistic limits, while bringing as much happiness as possible to your family, and at the same time being of some use and help to others. With these ambitions—which can be realized by anybody—you can not only *be* a success but also *know* and *feel* that you are. It follows that you'll be free of that gnawing sense of failure which drives so many people to drink. . . .

2. Learn to Stand on Your Own Feet

There's only one way to become self-reliant, and that's by *practicing* self-reliance. This means, first of all, that you must be absolutely determined that, from here on out, you will reach and carry out your own decisions, solve your own problems, and meet your obligations and responsibilities to the very best of your ability. And it means, too, that you will follow through on this resolve day after day, hour after hour, in definite concrete situations, involving matters both large and small.

This won't be any fun, especially if you've been used to shoving your problems and obligations onto other people, and always accustomed to taking the easy way out. But at least you won't have to get yourself sozzled in order to make your life livable.

3. Don't Be a Worrywart

While everybody does a certain amount of worrying, some people worry practically all the time. If it isn't one thing, it's a half-dozen others. For these chronic worriers just can't be happy, it seems, unless they're in a stew about SOMETHING. And all too many of these chronic worriers end up as chronic *drinkers.*

What makes them act the way they do? Well, one explanation has to do with something that might be called an *insecurity complex.*

In other words, the theory is that their habit of worry stems from a basic lack of inner confidence. Thus psychologists have found that persons who are harassed by self-doubt and a sense of inadequacy are always trying to find a kind of scapegoat for their anxiety feelings.

Because they're inwardly ashamed of their lack of confidence, they shift the blame for their anxiety to things or situations that are outside themselves or presumably beyond their control. . . .

One of the big troubles with worrywarts is that they just can't make up their minds about things. They may spend hours deciding what clothes to wear, which movie to go to, what or where to eat, which task to do first. And they may spend the greatest part of their lives vacillating about what occupation to follow or whom

to marry. . . .

If you tend to be the vacillating type, it's important for you to convince yourself of the fact that you'll be much better off in the long run by speeding up your decisions and sticking to them once you make them. When you can't decide whether to do this or that—and the decision isn't too momentous—flip a coin! You'll make mistakes, sure. But you probably won't make any more than you did before—and think of all the anguish and mental conflict you'll be saving yourself.

4. Refuse to Pity Yourself

There's no habit tougher to lick than that of self-pity. What makes it so hard to overcome is the fact that persons addicted to self-pity are always able to prove, at least to their own satisfaction, that they are thoroughly justified in feeling sorry for themselves. . . .

If you are inclined to self-pity, and have a genuine desire to get over this inclination, you should, first of all, analyze your behavior to make sure that your self-commiseration is not simply a convenient substitute for constructive action. Then, if you find that constructive action *is* possible, you should force yourself to do everything in your power to correct or improve the situation that's distressing you. . . .

5. Shun Suspicion and Resentment

Few of us can afford the luxury of entertaining a lot of grudges. Squaring accounts with people who've played mean tricks on us, or even thinking about it, can be an expensive pastime. Revenge may be sweet but you don't get it for nothing. . . .

But what you'd like to know is how, in certain situations, one can *keep* from feeling resentful and wanting to get even. What are you supposed to do, you ask, when for example someone takes credit for your bright idea, humiliates you in public, slights you socially, or betrays your confidence?

Well, the first thing you ought to do is make sure the offense was deliberate. . . .

As for those cases where you know, or are convinced, the injury was intentional, the situation may call for your doing something concrete and specific to protect your interests. Since no one should let himself be pushed around or treated as a doormat, you should, in some situations, assert yourself and fight right back.

Quite often, however, the question of self-defense or the preservation of your self-respect isn't involved at all. The damage has already been done and it's too late to repair it. Where this is true there's only one thing to do. That is to impress upon yourself the fact that you're merely making yourself tense, bitter and unhappy by cherishing your resentments—that you're *hurting yourself more than anybody else* by brooding about how you've been treated unfairly, insulted or take advantage of. Reasoning with yourself in this common-sense way should enable you, sooner or later, to forget the whole thing. . . .

6. Get It Out of Your System

Regardless of how tolerant and understanding we may try to be, there are bound to be some situations when we just can't help getting boiling mad. What does the science of mental hygiene tell us about situations like these?

It tells us, very explicitly, that anger, like steam, has to have an outlet—that the attempt to keep it bottled up can hurt us both physically and mentally, besides working mischief in other ways.

For repressed anger, studies show, can make our head or stomach ache, raise our blood pressure, and literally make us "pay through the nose" by bringing on certain respiratory

ailments.

When we fail to get it out of our system, our anger is also likely to express itself in any number of disguised forms, none of them pleasant. Thus our feelings of irritability, depression and disgust with ourselves and the world in general, are often merely the result of pent-up rage and anger. And it's feelings of this sort that help keep the liquor industry going. . . .

Does all this mean that we should make little or no attempt to control our anger? Of course not. What it does mean is that there are some occasions when we should release our anger directly, and others when we should find some safe and sane outlet for it. . . .

7. Be Tolerant of Yourself

You were urged, a ways back, to try to forgive and forget the mistakes and shortcomings of others. Well, it's every bit as essential to your emotional stability that you exercise the same tolerance toward *yourself.*

As an imperfect human being living in an imperfect world, it's inevitable that you should make mistakes. And some of them can be plenty serious. But far more important than your particular errors or sins of omission or commission is the attitude you take toward them. If you're wise, you'll analyze them, learn from them, profit by them, try not to repeat them. But above all, you won't make yourself sick and unhappy by castigating yourself for them, or feeling guilty and remorseful about them, when it can't do you or anybody else any good. . . .

8. Learn to Laugh At Yourself

Most of us are quick to see and enjoy a joke when it's on the other fellow. But when the laugh is at our expense, we may or may not be able to take it. Yet it's important, in more ways than one, that we do have this ability to laugh at our own foibles, frustrations and mishaps.

Why do you think most of the top radio and TV comedians let themselves be kidded and heckled so much on their shows. Sure, it's for laughs. But that's not all it's for. These shenanigans are calculated also to make them likable.

Well, the same principle holds in everyday life. Do you want people to like you? Then you must show you're able to take a joke and stand a reasonable amount of ribbing.

A sense of humor that can be directed toward yourself (as well as others) is valuable for an even more important reason: it helps preserve your mental health. It enables you, when things go wrong to discharge through laughter what might otherwise be unbearable tensions. It acts here as a kind of safety valve. And in general it keeps you from taking yourself along with your problems, troubles, plans and ambitions—too seriously. . . .

9. Recognize the Value of Work

From a mental health viewpoint, if for no other reason, everyone should work; and almost any kind of work is better than none. Work helps take your mind off your worries and troubles, can alone supply an adequate outlet for your energies, and gives your life a direction and a purpose.

Be sure, though, that you don't drive yourself too hard. And make sure, too, that your work, and your success in it, never become so all-fired important in your thinking that they mean more to you than *people.* . . .

10. Cultivate A Relaxed Attitude Toward Your Work

One reason many people drink excessively is to relieve feelings of tension and anxiety connected with their work. They get so steamed up about all the things they have to do;

(Continued on page 29)

Sober nearly a month,
this department store Santa was
building up to a "ripsnorter" on Christmas Eve.

No Wassail For Santa

A SHORT STORY BY GEORGE ADAMS

IT had been exactly 3 weeks and 4 days since Adam Booth donned a red velvet suit and stepped into his role as the Wheeler Department Store's Santa Claus. But to Adam the pentrating gaze of hundreds of children had made the time seem an eternity of painful, dragging hours. The children stared at him in such a peculiarly searching way that Adam was convinced they knew he was a fraud. Of course they did! And in discovering it they only reflected what Adam felt about himself.

A twenty-four carat lush in the role of the Patron Saint of Christmas! Hah! What a colossal, tragic joke, thought Adam.

He was still baffled as to why the personnel manager had chosen him over the other applicants. Did the red nose and ruddy cheeks attract him? Or perhaps the executive spotted Adam's ravelled suit and chalked collar and hired him in a burst of Christmas charity.

Adam didn't know how he got the job. And he didn't care now. He only cared that in a few hours he could get down off his wooden perch, hang up that itchy red suit and head for the Blue Moon Bar with two hundred and fifty dollars in his pocket.

"Two hundred and fifty smackeroos!", Adam murmered aloud, looking quickly around to see if anyone had heard. Let's see. How many drinks would that buy? At fifty cents a shot . . . if he stretched it . . . Who knows? Enough, at least to blot out the memory of a thousand pairs of staring eyes which had haunted him during his reign as Santa. Enough to kill the loneliness of Christmas Eve in a two-bit rooming house. Enough . . . enough. Adam moistened his lips in anticipation.

What a thirst he had raised in three weeks and three days! But he didn't give in to it. Not even one little shooter. He'd shown 'em all right. His drinking buddies said he'd never make it, had even placed bets on when Adam would fall off the wagon. And there were times when Adam was almost driven to prove them right. . .

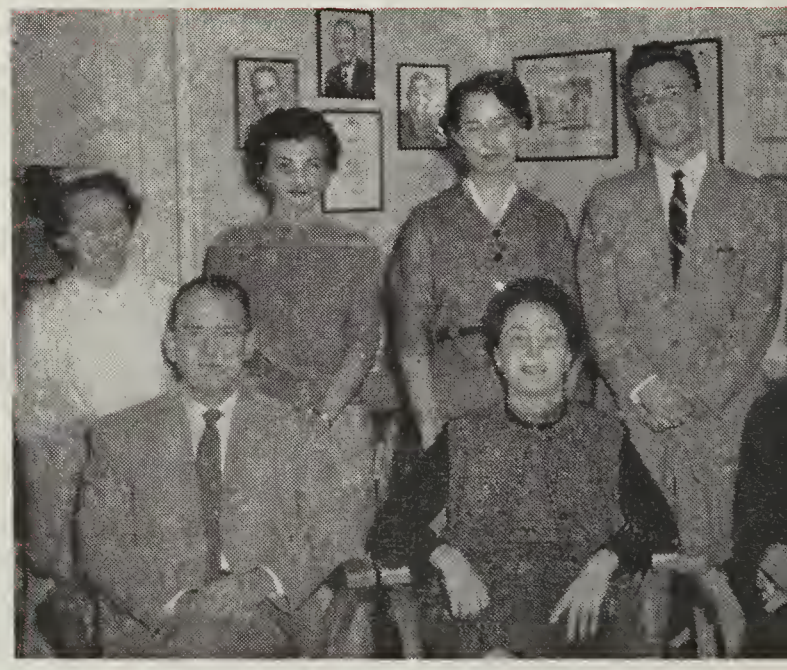
There was the day near the beginning of his stint when he almost blew his top at one of the store's best customers.

"Now, Santa," she purred, bending her face close to his, "little Johnny,

(Continued on page 18)


BLUE
MOON
BAR

Season



THE RALEIGH STAFF

Left to right: (seated) Norbert Kelly, Robe
S. K. Proctor. (standing) Left to right:
Brooks, Margaret Colovos, Claire Cheney
Adams, and Sue Bassett.

Greetings

from all the folks at the N. C. A. R. P.

tle,
nor
rge

THE BUTNER STAFF

Left to right: (seated) Angela Everett, R. R. Pulley, Roy Barham, Donald Macdonald, Janet Haas. (standing) Left to right: Daphine Ellis, Nat Woodlief, Margaret Keith, E. C. Keith, Marjorie Pearce, Frank Pearce, Mrs. G. B. Wall, and Margaret Curl.

bless his heart, is going to ask for a bicycle. But, Santa, you must talk the darling out of it. Bicycles are so terribly dangerous, and our Johnny is so young and inexperienced. Besides, he's a delicate child, not well at all. Well, Santa, do try to get him interested in one of those beau-u-utiful accordions there. You will do that, won't you, Santa de-e-ear? Shh, there's Johnny now."

Adam remembered, glancing around to see "delicate little" Johnny. He turned out to be a robust lad with a healthy crop of freckles, just bursting with the energy of youth. He looked again at the mother, now nervously fingering her fur neck piece, waiting for some sign of assent to her scheme.

Adam felt a blind flash of rage burst within him. He could almost trace it physically, as it boiled in his stomach and swelled into his chest. "Go to blazes," he thought, "Damned if I will help you make a pantywaist of that boy."

But just as the emotion almost burst from his throat, he shoved it back down somewhere inside. "Okay," he muttered, "the accordion it is."

He sat listening to his rapidly beating heart as Johnny climbed the steps to his chair. A neon sign flashed in his mind. Blue Moon Bar . . . Blue Moon Bar . . . Blue Moon Bar . . . off . . . on . . . off . . . on. Adam felt an almost uncontrollable desire to plunge headlong out of the store and down the avenue, red suit, beard and all, to the flashing sign and drown in an alcoholic deluge the rage that still smoldered within him.

But he didn't go, barely managing to defer immediate relief for the promise of a fat paycheck and a real rip snorter at the end of his stretch. He successfully talked Johnny out of his bicycle. But the same doubting look that Adam found in the eyes of the other children was in Johnny's eyes, too. "You're a fake," they seemed to whisper, "a great big red-nosed fake."

And if the eyes of the children had disturbed Adam, a single set of steely gray ones nearly sent him into a tailspin on more than one occasion. They belonged to the floor walker, Mr. Wilkins, one of the Wheeler Department Store's oldest and most trusted employees. Old Slickbritches, as Adam had tabbed him, was always hovering over like a little god. He was there when Adam arrived in the morning, thrusting his narrow nose close to Adam's face, surreptitiously checking for alcohol fumes. He was always on hand when Adam went for a smoke . . . "Remember, back at your post in five minutes, Mr. Booth." Yes, Mr. Wilkins. No, Mr. Wilkins. Adam hated him intensely. He hated him for always being around. He despised him for his breath checks. He hated Slickbritches because he wanted to tell him to go to hell and couldn't.

He hated him so much, Adam thought, that he could stay on the

LIQUID OCCUPATION

To hear 9-year-old Philip Billey tell it, you'd think his dad was the town drunk. George Billey was recently named director of the Grand Rapids alcoholism center. Philip, when asked his father's occupation, replied: "My father is the chief alcoholic in Grand Rapids."

wagon for three weeks and three days just for spite. And, by golly he had done it. Old Slickbritches should be around for breath check in the morning, Adam mused. I'd give him a blast that would put him under. He chuckled at the thought.

Adam's thoughts drifted back to the Blue Moon. He squirmed and glanced nervously at the clock on the wall. Just two and a half hours! He contemplated the spreading warmth of the first drink, breaking the long dry spell. His former companions would be glad to see him. It always reassured them to see one of their number fall off the wagon. They would accept him on face value—a fellow lush in need of a drink . . . and another . . . and another. Adam forced his mind to clamp shut on memories of the pain and hopelessness of the bender and the inevitable, excruciating hangover.

He was thinking again of the first several drinks, of the myriads of amber beads clinging to the sides of the shot glass, the camaraderie of the barroom. A dreamy smile crept across his lips.

Adam's boozey reverie was interrupted when he felt once again the gaze of a child's eyes upon him. They were large brown eyes, sunken in tired circles and tinged with sadness. They were the eyes of an old lady set into the head of a skinny little girl standing knock-kneed before Adam. One of the stragglers, he guessed. Pretty late to see Santa Claus. Oh well, probably my last customer. He mustered his best smile and invited the little girl to perch on his knee.

"Well, what's your name little lady?"

"Elizabeth," she replied in a tiny voice.

"Now, Elizabeth, did you forget to tell me about something you want?"

"Oh, no, its not about my toys," she said.

"What about then," Adam asked with a grin.

"My Daddy. I'd rather have him back for Christmas than to have the Princess Anne dolly I wrote you 'bout."

Adam grew serious now, sensing some tragedy about to unfold.

"Where is your Daddy, honey?"

"I don't know. I'm awful worried 'bout him. Mommy's worried about my Daddy, too. All of a sudden, he just went out of the house the other day and didn't come back. I miss him somethin' awful."

"I'm sure you do, Elizabeth," Adam said, giving her a clumsy pat on the head.

"Mommy says Daddy has been sick," Elizabeth continued. "He takes an awful lot of medicine out of a great big brown bottle with a pretty picture on the front. I don't b'lieve his medicine is any good, cause it doesn't make him well and he gets sorta' mad after he takes some of that stuff and starts yelling at Mommy and me. But anyway, I want him to come back 'cause he's my Daddy and I love him. And, Santa, you can drive reindeer through the sky, so can't you find my Daddy and bring him back to us?"

Looking into Elizabeth's eyes, Adam saw a childish faith he had found lacking in all the other children. He melted under her trusting gaze, swallowed hard and began floundering for words to assuage her

request. But what could he say? He imagined her father, lonely and guilt-ridden, holed up somewhere in the city, trying to find oblivion in a bottle of "medicine." But Adam knew from experience that he wouldn't find it.

"There comes my Mommy," exclaimed Elizabeth. "I'll have to go now. Please, Santa, bring my Daddy back for Christmas."

Before Adam could reply, Elizabeth's mother swooped down upon her, pulled her from his knee and scolded her severely for wandering.

"I've been telling Santa about Daddy," Elizabeth explained weakly, her hands instinctively clamped behind her back, palms-out.

"That's nobody else's business," the woman's words lashed out, spanking the child as effectively as their physical counterpart. Then she turned on Adam, eyes flashing resentment.

At a single glance, his impression of Elizabeth's mother stirred his memory. He saw the dark lines of sleeplessness about her eyes, the tightly set mouth, shoulders slumping under the burden of her secret, now divulged to a stranger. He had seen the same beaten yet defiant look stamped on the features of his own wife before she finally gave up and left him, never to return. For a moment, the sadness of his wasted years overwhelmed him. He felt infinite compassion for the wife he had lost and for this woman standing before him so full of hurt and anger. He wanted to help her, to say some word of hope and understanding. But he could find none.

Without speaking, the young woman turned abruptly on her heels, grabbed Elizabeth by the hand and strode briskly between the barren toy counters toward the nearby street exit.

"Wait!", Adam called but the woman did not respond. Only Elizabeth acknowledged his call, stealing a final pleading glance over her shoulder.

In the rush of departure, a yellow slip of paper fluttered down from the woman's hand. Adam, seeing the pair disappear through the door stepped from his stand and bent to pick up the paper. It was a store receipt bearing the woman's name and address. Adam read the name—"Mrs. Joe R. Faucette." Joe Faucette. Surely this couldn't be old "Spig" Faucette's wife. "Spig," habitue of the Blue Moon Bar, was one of Adam's favorite drinking companions. He checked the address—13 Liberty Street. "Well I'll be! That was Spig's address all right. Adam remembered escorting his friend home one night after an evening of overindulgence. In their drunken humour they had made jokes about the number 13 over the door and the misfortune it symbolized for Spig.

So the taut young woman was Spig Faucette's wife, Adam mused. Funny, he'd never thought of his friend's wife as being a real person at all. She had been only the subject of derisive jokes, a caricature—Maggie with a rolling pin. Her materialization as an attractive, though worn, young woman shocked Adam deeply.

Adam believed he knew exactly where Spig Faucette was. He had been there many times himself to

finish out a bender begun at the Blue Moon Bar. Hotel McElwain was the name of the establishment. It hadn't seen a sober guest in years. Two blocks down and around the corner from the Blue Moon. Very convenient. Eighteen squirrel cages with cold running water, streaked wall paper, sagging bed, and bottle opener in every room. Even the Gideons had given up on the Hotel Mac. Poor old Spig, running the treadmill to oblivion on Christmas Eve. Too bad.

"You may leave early tonight, Mr. Booth. I don't believe you will have any more customers this year." It was old Slickbritches. "I'll have your pay envelope for you when you've dressed."

"Yeah, okay. Thanks," Adam mumbled.

So it was over at last! When the realization struck Adam he got to his feet, climbed hurriedly down from his perch and dashed for the dressing room, banging the door shut behind him. After hanging up the velvet suit, he snatched the false hair off his face leaving two white strands dangling from the point of his chin. He pulled on his threadbare blue serge and hauled open the door.

Old Slickbritches was waiting with the pay envelope. Adam thought he caught a note of sarcasm in the floor walker's parting remark, but he ignored it. Without stopping to count his pay, Adam jammed the envelope into his pocket and headed for the street exit.

Upon reaching the street, Adam stopped for a moment to sniff the cold air then set his jaw decisively and plunged into the rushing crowds. He headed down the street, eyes set straight ahead trance-like, bumping and shoving people out of his way. His steps grew faster and faster in a furious pace until he reached a corner. Here he turned and glanced wistfully over his shoulder. Back in the middle of the block he could see the familiar sign flashing . . . Blue Moon Bar . . . Blue Moon Bar . . . Blue . . . Moon . . . Bar . . . Blue Moon Bar. Overhead, one naked bulb shone on a metal sign that swayed and creaked in the cold winter wind. Its faded gold lettering read, "Hotel McElwain. Reasonable Rates."

THE moment a person takes his mind off himself and applies it to the needs and welfare of others, he becomes alert, active, interested in life, and concerned with positive functioning. With this outlook, the world becomes full of real people, not merely walking shadows.

From MENTAL HEALTH IN A MAD WORLD by James A. Magner

THE problem drinker needs to realize that all-time-sobriety can be a pleasurable experience. And that his fun in the past will look—after he has a firm grasp on total sobriety—like a tricycle to a full-grown man, a no longer useful or desirable toy. He will find a priceless pleasure in having a clear head and an easy conscience; an ability and willingness to look anyone in the eye—including himself.

From HERE'S TO SOBRIETY By Thomas Fullam

The Butner Treatment Center is not for men alone. It also provides

HOPE FOR THE *Woman Alcoholic*

BY CLAIRE CHENEY

The woman patient unpacks her suitcase as she begins her 28-day treatment at the Alcoholic Rehab. Center.

A WOMAN carrying a suitcase gets out of a car and walks toward the large, white building that will be her home for the next 28 days. She is an alcoholic and she needs help. She is counting on the people inside the building to give her the help she needs, just as have hundreds of women before her.

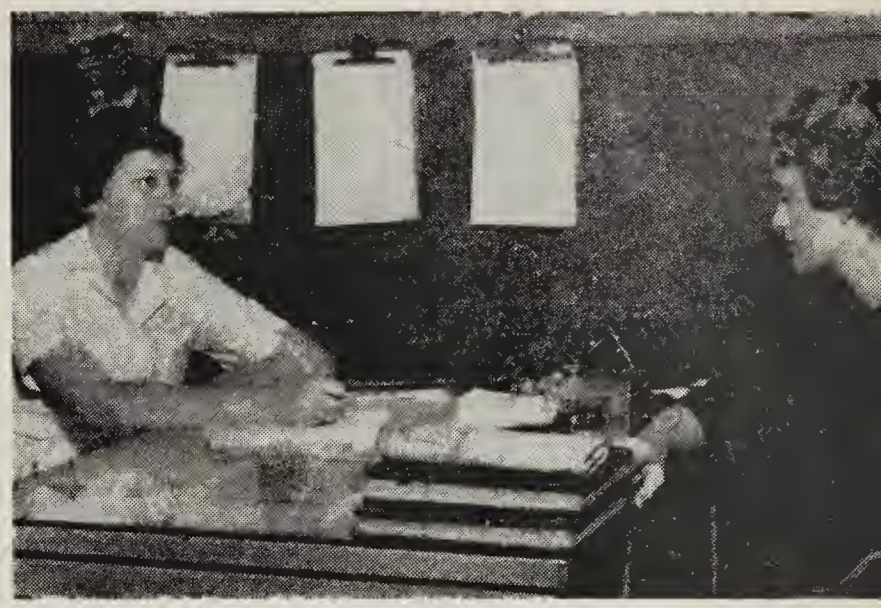
This is a scene enacted day after day at the Alcoholic Rehabilitation Center at Butner, operated by the N. C. Alcoholic Rehabilitation Program, S. K. Proctor, Director. Women from all over the State who suffer from the heartbreaking disease of alcoholism come to the Center looking for a solution to their problems. Many find it; some don't.

The "Secret" Disease

The woman alcoholic is much less prone to admit she suffers from compulsive, uncontrolled drinking than is the male. It is much harder for her to make an initial step toward seeking professional help since she fears that knowledge of her affliction will mean shame and disgrace. Over a million American women are suffering from this "secret" disease that is wrecking their lives and those of their families. Some studies show that one of four alcoholics are wom-

en; many are young and from educated, cultured backgrounds. For their illness they pay the price of social stigma and perhaps the loss of family, friends and job.

The women's wing at the Treatment Center has been in operation since January, 1954. At one time as many as twelve women patients are housed together in the dormitory-like rooms which they share. On the opposite side of the building is the men's wing which holds as many as forty male patients. During their stay at the Center, men and women patients are segregated, except in therapy and supervised recreational activities.



Patient gives vital facts about herself to Mrs. E. C. Keith, chief attendant.

Here patients enjoy chatting together as they carry on routine household duties.

Center Described

The area between the two wings is composed of a dining room, kitchen, offices, and two recreational areas, one for the men and one for the women. Here they find companionship around the card table, someone always willing to play a game of pool, magazines and newspapers to read, and a TV set for watching their

Angela Everett, occupational therapist shows patients the art of leatherwork.

favorite programs. If none of these activities appeals to the patients, they are free to sit around and talk.

There are no bars on the windows at the Center and no locked doors. The rooms are tastefully decorated and though simply furnished, convey an atmosphere of acceptance and hominess.

Admission Requirements

When a woman alcoholic realizes she must have help in overcoming her disease, she can write a letter to the Superintendent of the ARC, requesting an appointment for admission. Or she may ask a member of her family, a friend, physician or minister to write the letter for her. She should express her desire for voluntary admission and ordinarily will be admitted within two or three days after application.

Admission to the Center is by appointment only. No one may be admitted through a court order or by force. The fee for the 28-day stay is

In her first psychodrama, the woman patient learns to "act out" her reality problems as Janet Haas, clinical psychologist, observes.

All photos were posed by staff personnel. No patients are shown.

Group therapy, the Center's basic treatment method, helps patients gain more insight into their problems. Here Dr. C. A. Anderson leads a group.

$75.

The Alcoholic Treatment Center is not prepared to care for acute cases of alcoholism. A patient suffering from delirium tremens, for example, requires constant medical and nursing care which the Center is not equipped to give. All patients must be sober and in good physical condition when admitted. A letter from the patient's physician must be sent to the Center, noting any chronic diseases or conditions which might require special attention or diet.

Patient's Arrival

When a patient arrives at the Center, she registers in the office and has an opportunity to meet the staff, headed by Dr. Donald Macdonald, Clinical Director, and consisting of a chaplain, psychologist, consulting psychiatric social worker, attendants, and staff physicians from the State Hospital at Butner. She is then taken to the room she will occupy during her stay and is introduced to the other women patients. She finds that her room is amply furnished with attractive, tailored curtains at the windows. Her roommate may be of the same age or perhaps she's younger or older, but they will live together four weeks under their common bond of alcoholism.

She is probably timid when she first enters the Treatment Center. She knows little of what will be expected of her or what to expect herself. But soon her shyness disappears as she realizes everyone understands and sympathizes with her problems. Some patients will even have problems identical to hers and she is amazed at how small some of her troubles seem once she has talked them out with fellow patients and staff members. Gradually, as she becomes acquainted with the staff and patients, she feels that perhaps this therapeutic atmosphere is what she has been needing all along. Perhaps with their help and her cooperation, she can lick this thing called alcoholism which is ruining her life and the lives of those she loves.

Reasons For Drinking

There are various reasons why women find it necessary to turn to alcohol for comfort. It helps them become more sociable; it reduces fears and anxieties; anesthetizes personality problems; and furnishes relief from the tensions, conflicts, and frustrations of the career woman-housewife role. It is the job of the Center to reduce her tensions and fears, to help her feel wanted and secure; to help her realize joy and happiness from the "routine" life she may feel she's leading. Through group psychotherapy, the basis for the Center's treatment program, the woman alcoholic comes to understand herself and the pattern her life is taking. Many find they can live normally without drinking, where once the thought of a life without the crutch of alcohol was terrorizing to

"My dear Mother-in-law:

Attached to this note find your infant son. I have tried—years to help him grow up, but you beat me to him, and you are all he needs. So I send him back to you, just like I got him.

Faithfully yours,
Would-be-Wife

P. S. He eats most anything, provided it's like you fix it."

From MOTHERS AND SONS by Carlyle Marney

them.

The woman patient's day begins early in the morning. She dresses, cleans her room and goes downstairs to the large dining room where she joins her new friends in a hearty breakfast. Each morning at 10 o'clock, the patients assemble in the larger recreation room for the group therapy session, conducted by one of the clinical personnel. The session begins with the showing of a movie such as "Alcoholism", "Alcohol and the Human Body," "Feelings of Hostility" or many other films on alcohol education and personality development used by the Center. Following the movie presentation, the staff member leads the group in a discussion of what was shown in the film. The patients often see dramatizations of their own problems in these movies and thereby gain insight and understanding of their situation.

The patients speak freely in group therapy and there is much laughter and joking mingled with the more serious attitudes of some of the patients. One woman tells of her domineering mother who makes her feel inadequate; a young husband worries about his family situation; another fears he will lose his job because of drinking. These and many varied tears and anxieties of the alcoholics are discussed and analyzed, in the hope that some solution can be seen.

The lunch bell rings and the group therapy session adjourns until the next day. What new problems will be disclosed then? What new understanding and insight was gained today? Perhaps tomorrow someone will see himself with more clarity than ever before. These thoughts are in the minds of the patients and staff as they leave the session.

Each Monday afternoon a psychodrama session is held in the women's lounge under the direction of Miss Roberta Lytle, Psychiatric Social Work Consultant with the N. C. A. R. P., with Janet Haas, Clinical Psychologist, assisting. Rather than explain and talk about their problems as is done in group therapy, patients who participate in psychodrama *act out* their problems, thus giving themselves a rehearsal for the real-life situation they experience at home. The woman with the domineering mother tells her "mother" (played by a staff member) how she feels about being treated like a child. The "mother" then tells her side of the story. It is hoped that through this "role playing", the alcoholic will experience insight into why he or she has been unable to cope with the ordinary problems of living without drinking.

Many times the patient can gain a good comprehension of his situation and how to cope with it. She no longer needs alcoholic beverages and leaves the Treatment Center never to return again to drinking. Others, however, find it harder to adjust to a sober life and even though they sin-

THE ALCOHOLIC

THE alcoholic's problem—he is prone to think—is something special; something he must correct himself although his chances of doing it are almost nil. And he deludes himself in his attempts at self repair, for in the final analysis he rarely tries to quit drinking on an all-time basis. Instead he gropes for the old road back to controlled drinking; but the old road is gone. None has ever been able to find it again once it is lost.

From HERE'S TO SOBRIETY By Thomas Fullam

cerely want to stop drinking, are able to remain sober for only a short period of time. These patients may be readmitted to Butner for another 28 days.

The woman patient's spare time is taken up with sewing, reading, TV, talking or just resting. The occupational therapy building is equipped with tools and materials for her to learn leather work, weaving, wood refinishing or whatever craft strikes her interest. She is given instructions and supervision by the occupational therapist and is encouraged to carry on her hobby when she returns home. It has been found that wholesome recreation and the discovering or re-establishing of interests and hobbies will help in relieving tensions.

While at the Center, each patient is given individual consultation with the chaplain or another staff member, and a psychiatrist. Particularly pressing problems can be discussed privately at any time and each clinical staff member is always ready to listen and help the patients.

Although no visitors are allowed during the patient's stay, members of Alcoholics Anonymous hold regular meetings on Sunday afternoons. This is of great value to the patient who has not before become acquainted with AA and who perhaps would not seek help from AA except through this personal contact.

At the end of the four weeks at the Center, the woman patient is ready to go home. She smiles confidently as she waits at the door for her family, so different from when she first arrived. She has learned a great deal during the past weeks, but she knows this is only the beginning of her new life. There is still much to learn about herself and her illness. The Treatment Center has given her a start. She is ready now to begin out-patient treatment at the Mental Hygiene Clinic in her area and several nights a week will be attending AA meetings.

The Alcoholic Treatment Center is not a "cure-all." It is a cog and a very important one in the recommended treatment program outlined for the alcoholic. After the Center, it is hoped that the alcoholic and his or her family will attend the Mental Hygiene Clinic and AA regularly, and will keep in touch with their physician, minister and social service worker. All of these people are interested in and work toward the complete recovery of the alcoholic patient.

At present, there are 60,000 alcoholics in North Carolina. Many of this number are women. Quite a few have already been to the Center and are now leading sober, useful lives. But there are others who need help. The State of North Carolina has provided that help for her women alcoholics at the Alcoholic Treatment Center at Butner. The fee is only $75; the stay only 28 days. The result is new hope for the woman alcoholic.

THE SOCIAL DRINKER

THE average social drinker, and sometimes the problem drinker, recognizes when he has had too much to drink and can stop. He may deliberately get drunk to celebrate a special occasion or drink himself unconscious after a tragedy. Wisely or not, he sets out to arrive at this state of drunkenness or unconsciousness. But the alcoholic drinks compulsively. He rarely intends to get drunk but he always does. When he starts to drink he has no control even when his judgment tells him to stop.

From ALCOHOLISM IS A DISEASE by Marvin A. Block, M. D.

Personality Sketch

(Continued from page 2)

have sufficient time to delve adequately into any hidden motives.

Dr. Macdonald also stressed the importance of group therapy in the Center's treatment program and expressed a desire to continue group therapy as the main part of the program. "But we should not forget the value of individual therapy, either," said Dr. Macdonald. He then went on to outline three aims of the Center. (1) a more complete alcoholism education program. (2) a continuance and expansion of the group therapy program and (3) regular individual consultations with the patients.

Dr. Macdonald's knowledge and understanding of alcoholics comes from his extensive background in the field of medicine and psychiatry. After graduating from St. Andrews, he worked for a year as a houseman (interne) at the Dundee Royal Infirmary. From 1949-51, he served as Captain with the Royal Army Medical Corps in Egypt and East Africa, where he said aside from his medical duties, "he hunted giraffes for a man who worked with the London zoo."

Dr. Macdonald has always considered psychiatry the most interesting part of medicine, and the need for better facilities and personnel in the mental institutions was pointed up to him when he worked at the Dundee District Hospital from 1951 to 1952, and became dissatisfied with the largely custodial-type care given the patients. By then, he and his wife, the former Dorothy Flannagan, a nurse also from Scotland, realized the best psychiatric training was not available to him in England. This meant giving up their home in Scotland and making the long journey to the United States where he would hope to receive training of a higher quality.

But where would they go? This question was answered for them one day when Dr. Macdonald opened an English medical journal and saw an advertisement for a staff physician at the State Hospital, Butner, North Carolina. He replied to Dr. David A. Young, then General Superintendent of the Hospital, and was accepted. Dr. Macdonald says he answered that particular ad "because I liked the sound of the name, North Carolina."

For a young Scotsman who had never before visited New York, Dr. Macdonald found he knew a surprising lot about that grand city when he and Dorothy landed there in October, 1952, no doubt, he says, from movies, magazines and newsreels. And being city people, themselves, they felt quite at home in what they considered to be America. Imagine their shock when they came to Butner and found little there save the hospital grounds and rolling hills! "At first it took us quite a while to get used to the solitude," says Dr. Macdonald, "but now we love it."

From 1952 until 1954, the Macdonalds lived at Butner, where Dr. Macdonald served as staff physician. But soon realizing he wanted formal psychiatric training, he moved to Chapel Hill, where he became a psychiatric resident at N. C. Memorial Hospital. His love of Butner was not forgotten, though, and last July, his training completed, he became a full-time staff member and Clinical Director of the State Hospital and the Alcoholic Rehabilitation Center.

Alcoholism is not the problem in England that it is in the United States and Dr. Macdonald's first real experience with alcoholics occurred in 1952 when he first came to Butner. Since then, he has been constantly concerned with treatment facilities

for alcoholics and has new ideas for their betterment. "But," he says, "any changes to be made will be done slowly and with sureness. Any idea I ever had about burning up the world was knocked out of me in training."

Wives and husbands of alcoholics are all too often forgotten in an alcoholism treatment program, says Dr. Macdonald. He believes group therapy should be conducted for the spouses of alcoholics at the same time the alcoholic is in treatment. Eventually he hopes the Center will incorporate some sort of educational program for wives and husbands of the patients. In this way he feels they will come to better understand themselves and their spouse's illness.

Dr. Macdonald's hobbies include music and photography. He plays two instruments, the piano and organ. "My music," he says, "is my indoor hobby." "My photography takes me outdoors."

The Macdonalds love to travel and probably know more about North Carolina's geography than many natives. They're happy at Butner and the North Carolina Alcoholic Rehabilitation Program, for one, is very happy to have them.—*CC*

Program Pointers

(Continued from page 4)

Butner. Several stations have acknowledged receipt of the spots and of course, many of those stations which broadcast the announcements will not reply to us. We hope to continue using this medium permanently.

I'd like to thank all North Carolina radio stations for handling these announcements and for their cooperation with us in the past. I'd also like to ask our readers who hear the announcements to drop us a line and, of course, any time any of you have questions about the Program or treatment facilities available in the State please let us help you.

How To Keep From Becoming A Problem Drinker

(Continued from page 13)

or about the size and difficulty of a particular job, that they find it impossible to work efficiently; and the farther they get behind in their work, the more they drink.

If you have a problem of this sort, you must remind yourself, and keep reminding yourself that ANY undertaking—from straightening out a hall closet to carrying out a multi-million-dollar sales campaign—is nothing more than the sum total of its parts, and all one has to do, and can do, is concentrate on each part as one comes to it. . . .

11. Have Fun

Play is just as essential to a healthy personality as work. It not only loosens taut nerves and helps you forget your cares but gives you new zest and energy with which to meet the demands of daily living.

The best way to make sure you have enough fun and relaxation as you go along—without liquor—is to have a hobby. Passive pleasures like going to the movies, watching athletic contests, collapsing in front of your TV or reading whodunits are all right. But active ones that involve your mind and body are generally much more preferable. . . .

All you have to bear in mind in choosing a hobby is that you pick something you really enjoy doing, something you find genuinely relaxing. You may have to try out several before finding the one that best fills the bill. And there's no law of course against having more than one hobby

or riding a succession of them.

12. Find Something Bigger Than Yourself In Which to Believe

In scientific tests for measuring happiness that were conducted at Duke University, self-centered materialistic people netted the lowest score. Those who averaged high in altruism and religious attitudes, on the other hand, came out with the top happiness ratings. . . .

So it's clear, from all this scientific evidence, that one of the most dependable recipes for happiness—and one of the best preventives of alcoholism—is cultivation of the old-fashioned virtues of kindness, generosity and unselfishness, coupled with a positive belief in some higher power.

Chances are you'll find it a lot easier to follow this recipe if you have some church affiliation. Whatever their theological differences, all religious leaders and teachers are concerned with the same basic things. All of them emphasize respect for the essential rights of each personality and urge us to look beyond our personal desires and satisfactions and consider the needs of other people. All stress self-discipline. And all seek to provide us with a faith that will keep us from going to pieces in times of stress.

Pastoral Counseling

(Continued from page 9)

ing anyone else. But there are special implications in the psychological traits which are found in many problem drinkers. For example, it is hard for the alcoholic to relinquish the notion that he can learn to drink normally. He also feels sure that life without alcohol would be intolerable, and that he must lick the problem by himself.

Since alcoholics are proverbially slow in recognizing the existence of the disease in themselves, the first call for help may come from someone else. Often it will be the wife. Here the pastor must proceed with caution. By offering help through a third party, he may destroy the possibility of a constructive relationship. Until the alcoholic himself is ready to accept help the pastor should be content with indirect measures, perhaps laying the foundations for a good relationship with the family, perhaps counseling the wife. Helping her to understand the nature of the illness may produce unexpected fruit.

Unless the problem drinker is ready, it will do only harm to offer unsolicited advice; it puts him on the defensive. But this does not mean that nothing can be done. During a hangover, for instance, the alcoholic's defenses are temporarily down. The pastor can sometimes exploit such an occasion to explain the facts about alcoholism objectively, emphasizing the physical component of the disease as if he were describing diabetes or an allergy. This may be the moment to discuss Alcoholics Anonymous. It is best done in terms of some other alcoholic who has been helped, making the situation less personal and introducing A. A. principles in a more meaningful, concrete way. It is good strategy to ask permission to bring an A. A. member to visit.

When conversation gets to the alcoholic's specific problems, it is important to protect his ego so that he will not become defensive. This means, for instance, mentioning the ways in which he is hurting himself rather than hurting his family. But protecting an alcoholic's ego in this sense is not the same as protecting him from the consequences of his immature behavior. Anything that can be done to keep the reality situation before him without breaking therapeutic bonds

of acceptance can speed the time when he becomes ready to accept help.

In summary, then, the basis on which the first contact is made between pastor and alcoholic should determine the initial counseling approach. If someone other than the alcoholic himself has been the instigator, it is well to shift the initiative at the first possible movement—to force the alcoholic either to reject help or accept it on his own responsibility. Even if he rejects it now, he may come back later. The work done and the insights communicated are never totally wasted.

Technical Problems

Once a counseling relationship is established, various technical problems arise. The alcoholic tends to court and expect rejection. The pastor should therefore avoid saying anything which might be interpreted as passing judgment. In Clinebell's experience, "This is almost impossible if one does much talking, for the alcoholic will seize on anything which might be distorted to imply rejection." The soundest rule is to listen and to let him talk, meanwhile trying to grasp the feeling that lies behind the words. Letting him unburden himself freely is the basis of rapport. "If the counselor can keep from blocking the verbal and emotional flow," he will get the information needed to understand the dynamics of the problem. Even the man's most negative feelings must be expressed and accepted before they can be replaced by more positive ones. So let him talk it out, advises Clinebell. Repress the urge to interpret, reassure, or ask questions. "Seeming to pry into the person's life by questioning is a sure way of losing touch with his real emotional needs."

But the listening must be of a special kind. Because of his shattered self-respect, the feeling of being alone and under scrutiny makes the alcoholic intensely uncomfortable. To avoid this, the counselor must somehow communciate that he is with him emotionally—that they are working things out together. "Conveying this feeling is especially important in the case of a pastor because of the pedestal of perfection, a position detached from the common failings and foibles of humanity, on which some people think a minister lives."

Other Do's and Don'ts

Other do's and don'ts are examined by Clinebell. Combine acceptance with firmness, he urges. The alcoholic's emotional immaturity comes out in behavior that is selfish, childish, irresponsible, yet the pastor must sustain an accepting and nonjudgmental attitude. But it does not follow that the childishness should be overlooked. "On the contrary, only as the people around him are both accepting and firm will he be required to face the reality of the adult world and the destructive manner in which his irresponsibility affects his relationship with it. . . . A part of the firmness must be an implied insistence on the fact that people who are sick have an obligation to society to get treatment."

"The whole process of counseling alcoholics," Clinebell concludes, "is slow, tedious business in which one must be content with little successes. The alcoholic will not come out from behind his protective shell until he is gradually convinced that there are substitute satisfactions in other ways of living. As the counselor patiently holds the reality situation before him. he may gradually see the real grimness of his alcoholic adjustment, and become ready to accept the help he must have."

Books of Interest

THE TWELFTH STEP

By Thomas Randall

Charles Scribner's Sons

New York

568 pp. $4.95

THE newest novel about alcoholism to be published this fall is Thomas Randall's (pseudonym) "The Twelfth Step".

The title, taken from the AA Twelfth Step, gives an adequate description of this book which concerns the re-building of five different lives after they had emerged from the lowest depths of alcoholism. Mr. Randall has made a study of interrelationships and the value a common bond such as alcoholism has in the regrowth and self-examination which comes with sobriety.

The five dominating characters of the book meet in a "drying-out" hospital and from then on, their lives become entangled. There is Martin, a self-educated civil-service worker who quotes from Shakespeare and the philosophers. He meets Abbie, worn and dissipated from her way of life; David, a bartender whose life is governed by unknown fears and who searches vainly for peace; Helen, David's wife, who watches her husband deteriorate before her eyes, yet is helpless because she, too, cannot escape the bottle. There is Evelyn, an attractive housewife who drinks to alleviate frustration and boredom And finally, Ralph, a shoe salesman married to a selfish, dominating woman. These people struggle to help each other achieve sobriety and find through their dependence on others and with the help of Alcoholics Anonymous, they are able to establish new ideals and standards to replace their former way of life.

Mr. Randall is himself a member of Alcoholics Anonymous and thus writes with accuracy and from experience. He chose the pseudonym, Thomas Randall, in accordance with the traditions of the fellowship. Mr. Randall writes, "The failure of one person in the public eye could do more than offset the success of five thousand unknowns."

The author's father was an alcoholic and his parents' eventual separation caused him to be raised in an orphan asylum. Having seen the results of alcoholism at an early age, he swore to himself that he would never drink. "But," he writes, "the child of an alcoholic is filled with fear and bewilderment, is torn between love and aversion, and this later on makes him susceptible to the initially unifying and ego-inflating effects of alcohol."

Thomas Randall is now living with his family in New Hampshire and is a member of Alcoholics Anonymous. "The Twelfth Step" is an interesting book and one which most will enjoy reading. It is quite long, however, and the soul-searching and self-examination experienced by the characters becomes tedious at times.

The fellowship of Alcoholics Anonymous is, of course, quite prevalent throughout the book and the philosophy and spirituality of its message play a tremendous part in the five alcoholics' search for a genuine integrity. *—Claire Cheney*

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

N.C. Doc.
North Carolina State Library
Raleigh

JAN.-FEB., 1958

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Proudly Presenting A New Symbol . . .

THE STAR OF HOPE

Feeling that the fight against alcoholism should have a symbolic rallying point, the ARP staff scratched their heads, pawed the air, talked back and forth and, in collaboration with artist Bill Pugh, created the three-pointed Star of Hope for the Alcoholic. We hope that you like the new symbol and that you will help us see that it is as firmly established in the public mind as TB's double barred cross or cancer's sword. Meantime, write us your impressions of the Star of Hope.

The Editor's Page

ALCOHOLISM, NUTRITION AND DR. WILLIAMS

The work of biochemist, Dr. Roger J. Williams, has created quite a stir in the popular press lately. Through experimentation Dr. Williams claims to have established a relationship between heredity, nutrition and alcoholism. More simply, he believes that alcoholism is a disease stemming in large part from both an inborn or hereditary trait *and* nutritional deficiency. "The hereditary trait which predisposes toward the disease," says Dr. Williams, "is the possession of unusually high requirements for certain food elements." The ordinary diet is presumed not to supply enough of these elements, especially when quantities of alcohol are consumed. Deficiencies result and, according to the biochemist, are accompanied by a "craving" for alcohol.

In a recent address before the American Chemical Society, Dr. Williams went ever further in reporting findings indicating that potential alcoholics can be discovered in childhood. "By recognizing potential alcoholics early," says Williams, "and watching and adjusting their nutrition, we are confident that alcoholism can be prevented."

So goes Dr. Williams' theory to which, incidentally, he has applied the formidable term—genetotrophic.

There are numbers of people, alcoholics and otherwise, who are quite ready to swallow the genetotrophic theory hook, line and sinker. Perhaps some have already begun to gulp high-powered vitamin pills for alcoholism treatment or prevention. But without being blunt or unscientific, we are not ready to put the NCARP's education and treatment programs into mothballs simply because one scientist has rared back and passed a new theory. There are good reasons why we shouldn't be stampeded to the food supplement counters in search of a magical "cure for alcoholism,"

Though Dr. Williams is a reputable biochemist, it would be folly blindly to assume that his theory, based on limited experimentation, is valid. The scientific spirit is not one which accepts anything unquestioningly. Scientists in all fields are constantly advancing tentative hypotheses. Before we can either consign them to the ash can or elevate them to places of authority, theories must be subjected to scrutiny and testing by other scientists. For every new theory that is substantiated, hundreds more fall apart at the seams under closer examination.

It is only fair to state that there are other scientists working today

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Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

For the third consecutive year, we are cooperating with the state nurses' professional organizations in sponsoring a Nurses' Institute on Alcoholism. The response to last year's Institute held in Asheville and Greenville was so great that we at the ARP and the three other sponsoring organizations felt it necessary to plan a 1958 Institute with the idea in mind of making this an annual occasion. This year's Institute will be held in Greensboro on April 30, as part of the Greensboro Alcoholism Education Week. Those on the planning committee are Dr. Norbert Kelly, of the ARP, Dorothy Boone, Public Health Nursing Consultant for the State Board of Health, Evangeline Soutsos, of the N. C. League for Nursing and Bettie Baise, of the N. C. State Nurses' Association.

Soon our announcements will be going out concerning the scholarships we give each year to the Yale Summer School of Alcohol Studies. We will welcome your inquiries concerning our scholarship program and will be glad to send you details about the Summer School, with an application enclosed.

Star of Hope

A new addition to our Program is our symbol, the three-pointed star, which we hope will soon be identified with us. Our star is the Star of Hope for the Alcoholic and we will use it on our literature and promotional material. You can read more about our symbol elsewhere in INVENTORY.

It's budget preparation time again. We are preparing our budget for the next biennium 1959-60, earlier this year than in previous years due to a change in policy in the State Department of Administration. Heretofore, budgets have been submitted in September. This has meant the Advisory Budget Commission and the Budget Bureau have had little time to study the budget, make the recommendations and print the Budget Book for the Legislature which convenes in January. This new arrangement means the Advisory Budget Commission will have a better opportunity to study the budget and the needs and requirements of the various Agencies. While these are very real advantages, it places the Agencies in a more difficult position since we must prepare a budget in January for a two-year period that begins 18 months hence.

For quite some time we have been aware that our increasing mailing list has taxed our finances to the breaking point. Although we received an increase in our appropriation to cover the costs of printing and publishing, the amount of money appropriated has not met our requests for INVENTORY and other literature. After studying various ways in

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VOL. VII, NO. 5 INVENTORY JANUARY-FEBRUARY, 1958

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

THE PSYCHIATRIST

Object of much nonsense and untruth, he is a highly skilled medical specialist in a demanding profession.

To many alcoholics he is a "head shrinker" or a "skull jockey." To some of his colleagues in the other medical specialties, he has "gone off the deep end." But in a day when mental illness, suicides, alcoholism, psychosomatic illness and other symptoms of unhappiness are on the increase, the psychiatrist is a leading topic of conversation. Much of what is being said about him is plain nonsense.

What is a psychiatrist, anyway?

First, he is a physician—an M. D. —who has done many additional years of postgraduate medical study. In this, he is no different from other specialists—the internist, pediatrician, surgeon and others. His particular specialty is the diagnosis and treatment of mental and emotional disorders.

The *psychoanalyst* is a psychiatrist, too, who has had several years more of intensive study in the practice of his specialty, called psychoanalysis. There exist a few psychoanalysts who do not have graduate medical degrees and these practitioners are called lay analysts.

Many people hesitate to consult a psychiatrist, imagining that by simply walking into his office, they will be thought "crazy." It is true that psychiatry began with the treatment of the psychotic or insane. Today, however, treatment of this severely ill patient is largely confined to the mental hospital with its resident staff of psychiatrists. Mental hospital treatment is only a portion of the total scope of psychiatric practice.

Neurotic Patients

The great majority of the psychiatrist's patients are "neurotic." That is, they are suffering from inner problems so severe as to hamper their ability to carry on the day-to-day activities of living and associating with others. Their presenting symptoms may be intense fears, anxiety, tension, alcoholism, psycho-

somatic illness, chronic overeating or any one of scores of others.

Unfortunately, many of these disorders are at the outset considered minor. Nine times out of ten an individual will try to handle his problem alone. He blames it on his nerves, poor digestion, or overwork. He can "handle it", so he thinks. To attempt to handle a severe emotional problem is only asking for trouble. Serious emotional problems are deep-rooted and the individual is often totally unaware of their true nature. The specialized technique of the psychiatrist is needed to help the patient uncover and deal with them effectively.

Sometimes emotional illness is precipitated by some shock or damage to body organs. The disorders caused by brain injuries, certain types of poisoning and dietary deficiencies are in this category. In other cases the physical disturbance of the patient may be the *result* rather than the cause of emotional difficulties. The psychiatrist's special training qualifies him to distinguish between the two and to treat both.

Misunderstanding of Terms

People whose knowledge of psychiatry is superficial often complain that the psychiatrist "blames everything on sex." This results from a misunderstanding of terms. Mention sex and the average person thinks only of sexual activity. When the psychiatrist talks about sex he is talking about a basic life force or drive for pleasure and self preservation. It includes the universal need for a warm, close relationship with another human being, the longing to love and be loved and cared for. Sexual activity is only one aspect of the total sexual drive. Freud called this life force *Eros,* and believed that it was present in all human beings. When Eros is stifled or repressed, through harsh, restrictive child rearing, it may carry serious consequences. This may make the difference between a warm, loving person and a rigid, unhappy one. Many of the personal problems the psychiatrist is called upon to treat have their roots in the repression of the erotic drive.

The great majority of emotional difficulties begin in childhood but may not show up until adulthood. The child is born completely helpless. He is dependent upon his parents for physical care and for meeting his emotional needs for love and security. The child's feelings and attitudes about himself and his environment are largely determined by the extent to which his needs are met or denied. Overly harsh, repressive child rearing, for example, may increase the child's feelings of anger and rage. Since it is too threatening for him to risk rejection by expressing his hostility openly, he conceals it. He puts it out of his conscious mind and is actually no longer aware of its existence. In adult life, the smouldering anger often pushes its way to the surface in devious ways; recurring depression, inferiority feelings, psychosomatic disorders, alcoholism, anti-social behavior, fits of temper.

Encourage Talking

The psychiatrist's job is to help patients recall and re-experience the happenings and emotions of the past which are causing their emotional illness. Obviously, patients can't go back to Mother's knee, reliving their childhood. But the psychiatrist does the next best thing. He encourages patients to "talk things out." He sets himself apart by his technique—listening. He remains an *objective* observer, suggesting, commenting, but never passing judgment on any material the patient reveals. His ob-

jectivity enables the patient to transfer to the psychiatrist his real feelings toward the important people in his past. During the course of therapy, he becomes the object of such feelings as love, anger, hostility, dependence—almost the entire range of human emotions.

Acts As A Guide

The psychiatrist provides the permissive atmosphere wherein the patient can bring these feelings into the open, see them, understand them and their effects. He acts as a guide along the uncharted pathways to self-acceptance. He does not solve problems; rather, he helps the patient to solve his own.

Ordinarily, the patient who goes to a doctor expects to dump all his medical problems in the doctor's lap, saying in effect, "Now do something." Because the psychiatrist bounces the problem right back to the patient, he rarely conjures up in the public eye the warm, reassuring picture of "My Doctor." Sometimes his suggestion that the patient "do something" in treatment is greeted with anger and resentment. But the psychiatrist is prepared to recognize this for what it is—normal resistance to expressing true feelings. He understands that this resistance is present to some degree in all human beings and particularly in those who are emotionally sick.

Psychiatric treatment is usually a long process. The unhealthy feelings and attitudes of the sick patient have developed over a long period of time. They have become interwoven in his whole pattern of living. They cannot be changed overnight.

Because treatment does often extend over a long period, the patient may at times become discouraged, anxious or fearful. The psychiatrist understands this as a normal occurrence and doesn't fret over it. He observes that his patients often appear worse just before they are about to take a dramatic turn for the better.

Few Miracles Accomplished

The psychiatrist accomplishes few miracles. There is nothing mysterious about what he does. The person under treatment does not shed his former identity and emerge a completely new or different person. Only the sick part of the personality changes. Freed from unconscious hatreds, fears and anxieties, the individual successfully completing treatment relinquishes his childish behavior patterns. Under the psychiatrist's guidance the patient has developed the inner strength to be himself.

A COMMON DENOMINATOR

IT has been established that alcoholics share in common a particular personality. Those people addicted to alcohol are chronically dissatisfied with themselves; they are compliant individuals anxious to gain recognition but continually depressed by their own feeling of inadequacy. The danger of suicide during the remorseful stage following a binge is well known and illustrates the latter point. Alcoholics suffer from overactive, highly punishing consciences and vacillate between morbid, self-punishing responses to their guilt and alcoholic rebellion against it. These factors and others must be taken into consideration in therapy, because the primary objective is to supply the patient with sufficient self-confidence so that alcohol will not longer be necessary to provide it.

Via "Chit-Chat"

The Woman

Whether it's champagne or muscatel, "respectability" or poverty she has more problems than alcoholism.

About 700,000 American women are alcoholics. Interest in the problem of these women is growing. Articles in the popular press, often keyed on a somewhat hysterical note, tend to give the impression that alcoholism among women is increasing at an alarming rate, although there is no proof of any such dramatic ocurrence. In the absence of a body of solid information about the characteristics of the women who become alcoholics, impressionistic writing and speculation as to the cause of alcoholism in women are the rule rather than the exception even in the scientific literature.

Is there a special etiology of alcoholism in women? Are women alcoholics fundamentally more disturbed, more deeply neurotic, than men alcoholics? Is there a relation between alcoholism in women and the special feminine physiological function? Does full-fledged alcoholism develop in women more rapidly than in men? Is the onset of alcoholism in women more likely to be related to specific events and environmental pressure? Does the woman alcoholic typically offer a picture of sexual maladjustment or misbehavior? Is alcoholism in women likely to be connected with inability to accept the feminine role in society where the concept of the feminine role is itself confused and in a state of flux? Finally, are women alcoholics more difficult to treat than men? All these ideas have been suggested in discussions of the women alcoholic.

Edith Lisansky has attempted to find factual answers for some of these questions by comparing the records of 46 women alcoholics and 55 men alcoholics, randomly selected, who came voluntarily for treatment to outpatient clinics in Connecticut, and 37 women alcoholics committed to a State Farm for various offenses.

Among the outpatients, the men and women alcoholics presented rather similar social pictures. They were alike in average age, education, occupational status, father's occupation, and religious and ethnic backgrounds. A little over 40 percent of both the men and the women had a childhood history of at least one parent, usually the father, being lost through desertion, separation, divorce or death.

There were a few differences, however. Of the women, 44 per-

Alcoholic

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cent had a father or mother and 24 percent a brother or sister who was a problem drinker, while among the men only 35 percent had a parent and 9 percent a sibling problem drinker. A clear difference emerged also in the patients' descriptions of their mothers and fathers. Among the men, only 9 percent thought of their mothers as "strict and controlling" while 29 percent of the women did so. On the other hand, 23 percent of the men and only 9 percent of the women considered their fathers strict and controlling. This finding is in agreement with recent observations in France and in Austria, where the woman alcoholic has been described as unable to identify with her mother, denying her own feminine role and identifying with her father.

Marital disruption was equally common to both men and women alcoholics. And both the men and the women had been married more often to problem drinkers than chance alone would allow.

It is in the area of the drinking histories that sex differences are most clearly marked. The average age at which the men took their first drink was 17 while for the women it was nearly 21. The men appeared at the clinic for treatment after an average of 12.3 years of problem drinking; the women, after 9.9 years. This is consistent with the suggestion that the development of alcoholism in women is more rapid, its phases less clearly marked. Over half the women reported that they drank alone, compared to only one out of five of the men. The women frequently sipped at home during the day and went to bed with the bottle. "Plateau" drinking, the steadily repeated imbibing of small amounts of alcohol, which has been observed among men on Skid Row, may be characteristic also of the respectable women alcoholics.

The "reasons for drinking" given by the men and women clinic patients—often, of course, sheer rationalizations — showed a distinct difference: All but two of the women mentioned a specific experience, as a divorce, an operation, the death of a parent. The men, on the other hand, mentioned tension, shyness, boredom, and like generalities. It may well be that events and environ-

(Continued on page 31)

"How Can I Make My Friends Understand?"

By CLAIRE CHENEY

"HOW can I make friends understand that I can no longer drink? I don't want them to think I can't hold my liquor."

This question is asked many times by the newly recovered alcoholic as he leaves for home after days or weeks of treatment. One of the many problems facing him is his relationship with friends back home. Should he break off all past associations even though he and his family might have had the same friends for ten years or more? Or should he now confine his friendships with AA only? He feels "different" from his older friends; they're not alcoholics; they won't understand, whereas in AA he will have to make no explanations or excuses about himself. His wavering sobriety will not be threatened in AA; he will be accepted automatically within the tightly-knit AA circle. He will be safe.

During the first few months of sobriety to cling to AA for dear life is natural and wise. At that time the alcoholic is most sensitive, in desperate need for support and friendship. His constant fear is that his water wagon will break down. The understanding and acceptance he finds in AA is a salve to a damaged ego and he needs it to build his confidence up to a peak where he can face his life again. But is it mature to use AA as sole support indefinitely? Would it not be fairer to mix AA friendships with outside friendships —fairer to the alcoholic? Fairer to his family, who would find it difficult to cast aside all outside contacts for AA contacts only?

But if the alcoholic decides to combine old friendships with new, he will have to face the problem of guarding his sobriety and making those old, familiar, non-alcoholic friends understand why he cannot accept that martini, that beer after a movie, And he must do it in a way that they will respect and admire him for his honesty and courage. He cannot "cry in his ginger ale" over his affliction. There will be the inevitability of the cocktail hour, the social drink before dinner so enjoyed by his friends, the "quick one" between dances. If the alcoholic decides he wants to rekindle old friendships he will have to learn to expect these things.

Refusal Possible

There is the possibility the alcoholic could refuse all invitations where alcohol will be served and this might not be a bad idea during the early stages of sobriety, but for the more seasoned recovered alcoholic, it is not the answer. For Alan S., an alcoholic now sober after twenty years

"I have been ill," he told them. "I am not

Old and dear friends are sometimes the hardest to talk to, especially for the alcoholic. What's needed is a little understanding on both sides.

crazy and my sickness isn't contagious"

of inebriety, the solution was simple and straight-forward.

Alan and Alice S. at one time had enjoyed an entirely adequate social life with four couples, all of whom had known each other since their youth. Bridge parties, an occasional cocktail party, beach picnics, these were the forms of entertainment Alan and Alice experienced with these intimate, affectionate friends. But as Alan's drinking progressed, he made excuses to stay away from these get-togethers and soon practically all contacts with his friends vanished, even though Alice tried vainly to persuade Alan to join in with the group. Making small talk and being sociable would interfere with the one important thing in Alan's life, drinking, and he didn't want to be distracted from that occupation, even though liquor was always available in large quantities at these gatherings.

Friends Were Worried

Alan's friends knew he was drinking too heavily and too often and secretly they worried about it, but because they didn't want to hurt Alan's feelings or upset him, they kept their fears to themselves.

When Alan realized the hold alcohol had taken on his life, he was frightened, but fortunately, Alice was able to persuade him to enter a treatment center. After a few weeks Alan joined AA, Alice became a member of Al-Anon and together they gained insight and understanding of Alan's basic insecurity and resentments for which he had used excessive doses of alcohol as the treacherous remedy.

In the weekly AA meetings, Alan was surrounded by a circle of friends who shared similar experiences and emotions. With their help his old resentments and attitudes fell away. He "let his hair down" so to speak and relaxed his armed vigil against the outside world. Gradually he learned to give and take.

But Alan's problems were far from solved. Although he relied on AA for security, he felt a need to re-join the old gang. Not the barroom gang, for he knew now they were only drinking buddies—but his old friends. These were the ones he wanted to be with and although he had seen them on several occasions since joining AA, the old camaraderie had been lacking, no knee-slapping or telling of jokes. Everyone seemed to be trying too hard. There were sounds of forced laughter and then silence. Smiles seemed to be frozen on faces that had once been gay and outgoing as they turned to listen to Alan's every word, as if to seem distracted would have been the height of rudeness. "What do they think I am, Exhibit A?" he asked himself. He could feel the old resentments and fear of being left out mounting up. He became suspicious of every look exchanged among themselves He was sure they were signaling their boredom with their eyes. How condescending the wives were to Alice! How thoughtful of them to serve only punch when he knew they were just waiting for his back to turn before they ran out to the kitchen for a quick snort! What's wrong with us, he thought. Was liquor the only basis for our friendship and now that that's out for me, they no longer want us around? Are they trying to freeze us out? No, he knew that was not the answer. These people were his friends and somehow he had to take the initiative in putting things on the old, familiar basis. He had to—or else he would lose all the confidence and self-respect he had worked so hard to obtain.

"I have been ill," he told his friends one night when silence hung heavy

after exhausting themselves of all topics of conversation. "I am not suffering from a lack of manhood or a weak spine, as some of you might think. I simply cannot take alcohol like the rest of you and it's as simple as that. I am not crazy and my sickness is not contagious. But if you don't want Alice and me around, then just say so, but don't continue to treat us like strangers. We've known each other for years but this barrier between us—this barrier you've built around yourselves—has completely shut us out. It's as if we've never known you.

"If you want to drink, drink out in the open. Don't hide the liquor from me. I'm not so weak that I can't stand the sight of other people taking a drink. Sneaking drinks, running out to the car two or three times in an evening, locking the whiskey cabinet, you don't know how small and weak that makes me feel. If you want a drink, take one. Don't point up my sickness by serving only non-alcoholic drinks when I'm around. I want you to feel natural around us, not ill at ease and self-conscious. Relax and be your old selves. I need all the help I can get to stay sober, and sitting on the edge of your seats whenever I'm around will do more to promote a real winging of a binge than anything I can think of." Alan's voice took on a sober note, "But . . . if you can't accept me as I am, then perhaps I'd better find some new friends."

A Misunderstanding

It then came out that Alan's friends had not understood alcoholism or the alcoholic. They thought they had been doing the right thing by avoiding the subject, pretending nothing had happened—yet every word and gesture gave them away. They didn't know how to act around Alan and consequently were awkward and strained in their relationship. Alan, in turn, was resentful and angry at what he thought were deliberate slams. As it turned out, Alan's friends admired him more than ever for having the courage to recognize and live by his limitations. They solved the problem of serving alcoholic beverages by always having something special for Alan, but never making a point of serving it to him. Soon Alan learned to take his soda or fruit juice with the same aplomb his friends took their cocktails.

Alan's Way

This is the way Alan solved his problem, but think how much pain could have been spared if he had only spoken out earlier. Although Alan's solution will not work for every recovered alcoholic (there are many alcoholics whose sobriety is so shaky that seeing their friends enjoying an alcoholic drink would severely damage their confidence, frankness and honesty with yourself and your friends is always desirable.

John A. had a similar situation to face. But he thought the best way to solve his problem was just to pretend it wasn't there. Consequently when his friends were cool and reserved toward him out of shyness, he misunderstood and allowed his resentment to take hold. He refused to accept or return their invitations to parties, he crossed the street when he saw them heading his way, and he was curt and brisk on the phone. He wanted to resume his friendship with these people, but he didn't know how. It was embarrassing to admit his illness and since he was not sure he could be wholly accepted back into the group, he ignored them and crept to the protective nest of AA. Here were his real friends, he reasoned. They understood him, did not threaten or

challenge him.

Admittedly John A. took the easier way out, In a sense when he gave up whiskey, he gave up fighting, for to have to make the struggle to gain acceptance in the world outside AA would have been too much of a threat to his sobriety. However, John felt he had all he wanted in AA.

Worth The Risk

Alan, however, preferred the harder way. It was worth it to him to fight his way back into his former circle of friends. He found out that most people are becoming educated to the fact that alcoholism is an illness and admitting you suffer from this illness today is not much more alarming than saying you suffer from ulcers or migraine headaches. People, though, are still shy about bringing up the subject of drinking to an alcoholic, even though they know him well. The recovered alcoholic must understand this shyness and prepare for it.

When friends of an alcoholic treat him as if he were made of glass when he'd much rather be treated as one of the gang, he must realize that his friends see him much as they see a blind or crippled person. Since they're afraid of being "too nice" or "too condescending" yet at the same time don't want to hurt his feelings, they may be aloof, overprotective, defensive, tense, or just generally uncomfortable. But as the blind person explains his limitations to his friends and asks their help when he must cross streets or walk into an unfamiliar room, the alcoholic must do the same and say in essence, "I need your help in becoming a worthwhile member of my family and community."

To find that he is accepted among his non-alcoholic friends as well as in AA is of tremendous importance to the alcoholic's pride. It means he has gained poise and control of situations which previously might have thrown him into a whirlwind of confusion, as when someone makes a tactless remark concerning an area in which he is most sensitive. He learns to talk calmly and well, even to argue a point of view without becoming angry. He listens to what other people have to say without immediately jumping on the defensive. He is becoming Sober.

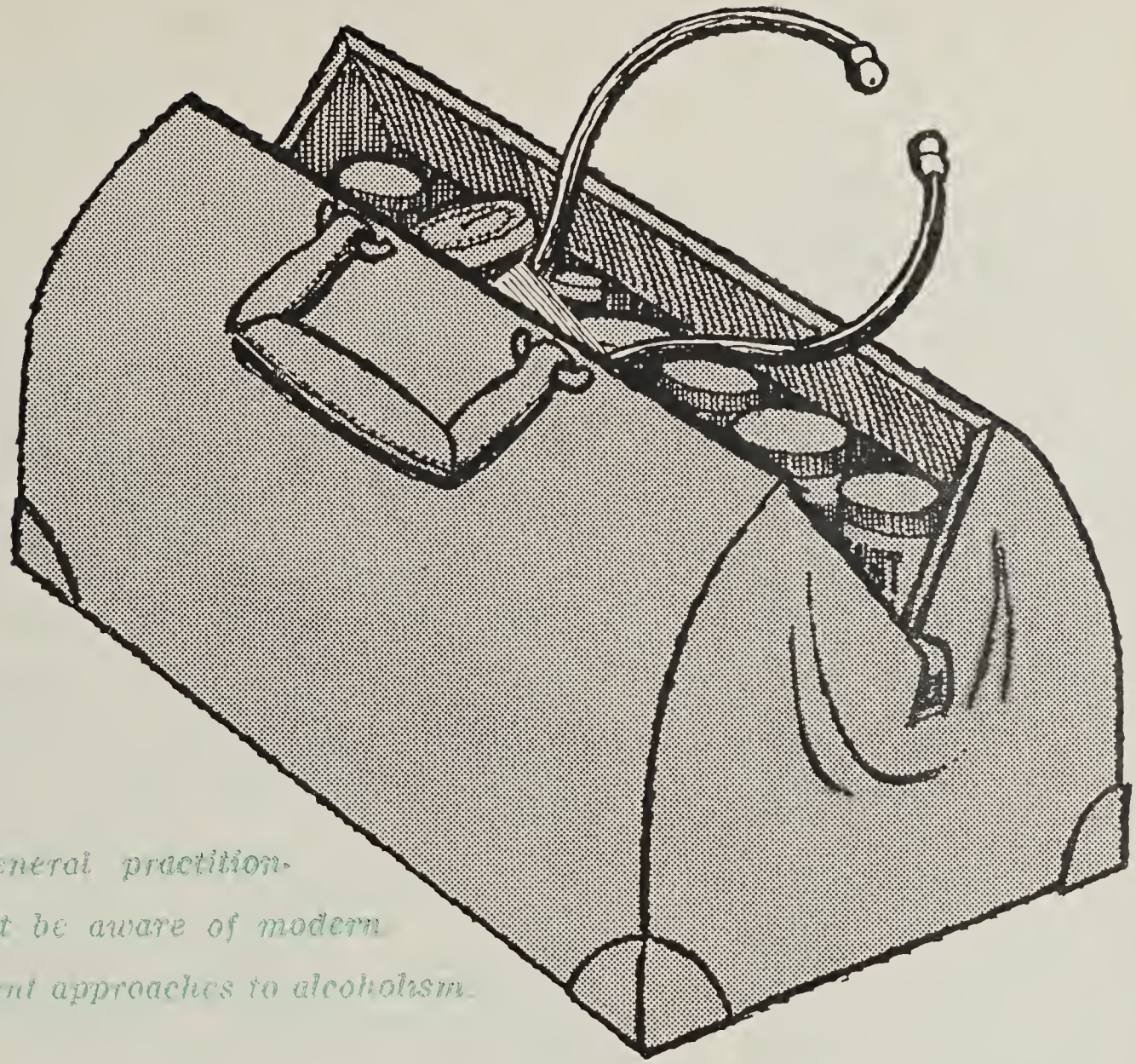
When drinks are served, the recovered alcoholic confidently sips his punch or soda and finds to his amazement that he enjoys it as much as he once did a cocktail. It's not necessary now for him to be the center of the group . . . he likes just being a part of it.

While AA offers him the certain amount of insight necessary to combat the inevitable troublesome areas in his life, his interest in things and people expands to the point where he never knew such riches and rewards existed. He gives fully of himself to his family and friends without thought of self-benefit. The alcoholic becomes Sober.

PANTY-WAIST?

Many people still seem to think that drinking is a manly art, that anyone who cannot or does not drink is a weakling or a "panty-waist." This belief is a hangover, if one may use that word here, of an ancient myth that identified intoxicating beverages with life and strength. To think that way today is ridiculous. To taunt a person who is unable to drink safely can have tragic consequences.

From HOW TO HELP AN ALCOHOLIC
by Clifford J. Earle



The general practitioner must be aware of modern treatment approaches to alcoholism.

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The Generalist's Role

BY SIDNEY VOGEL, M.D.

Treatment of the alcoholic is definitely within your province as a general practitioner, even though a feeling of helplessness combined with other influences may prompt you to avoid it. In any case, the fact is that when alcoholics or members of their families decide to seek help, it is the family doctor to whom they are likely to come.

This creates two problems for you which you don't have in your day-to-day experiences with ordinary patients. In the first place, you probably have very definite personal feelings about alcoholics which make it difficult for you to adopt your usual objective medical viewpoint with them. In the second place, the etiology, dynamics and therapy of alcoholism are not too well defined

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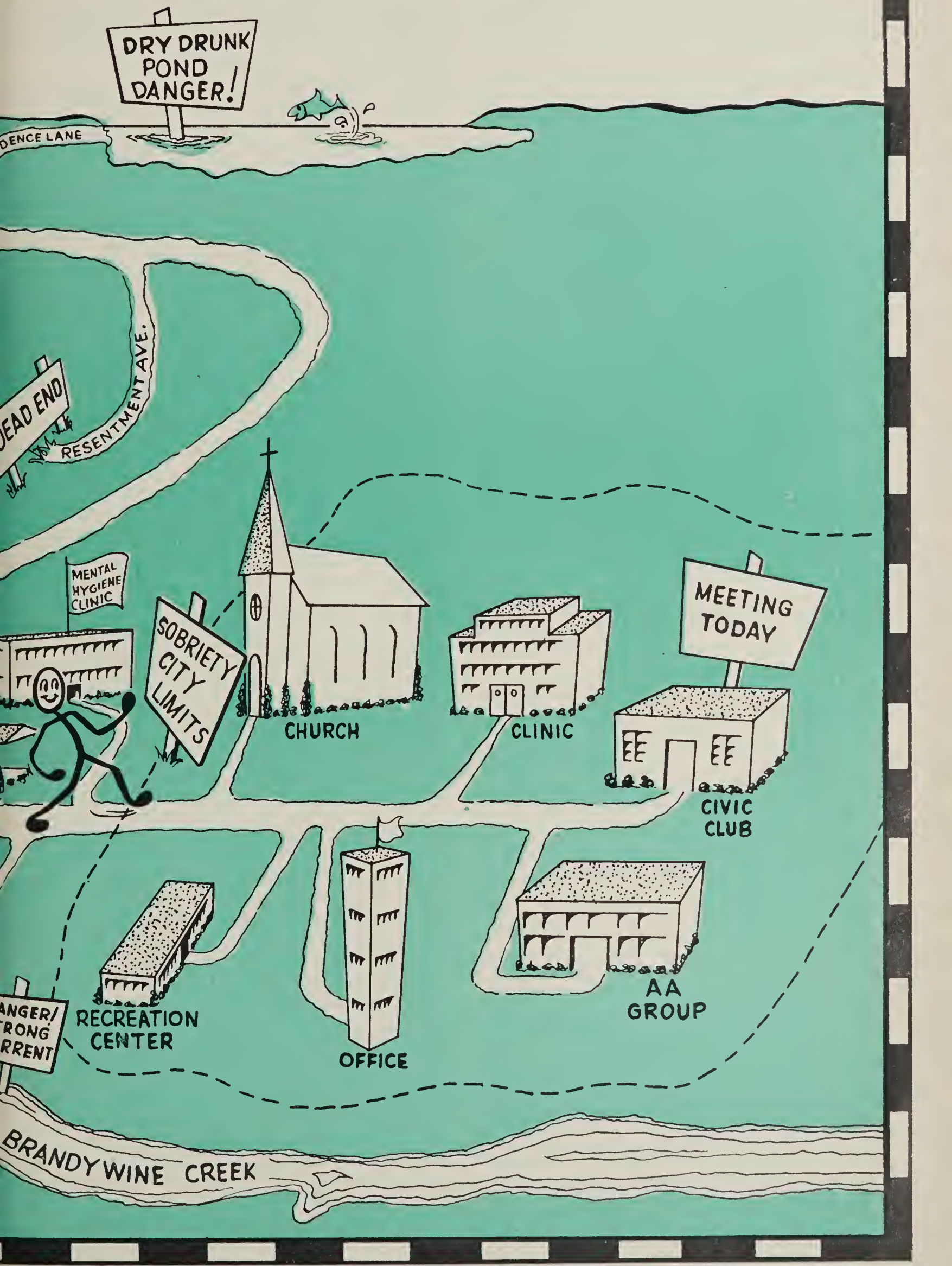
MOUNTAINS of EGO
Joe Alky
GUIDED TOURS
ROAD to SOBRIETY
PASTOR'S STUDY
TREATMENT CENTER
DETOUR
SLIPpery ROAD
HOSPITAL
M.D.
AL-ANON
AL-ANON MEETING
HAPPY HOME
A.A.
VALLEY of DESPAIR
Home of BROKEN PROMISES, ALIBIS, EXCUSES, RESENTMENTS, FRUSTRATIONS, & DEPRESSIONS
DEAD END
ROAD TO SOBRIETY


DRY DRUNK POND DANGER!
DENCE LANE
RESENTMENT AVE.
EAD END
MENTAL HYGIENE CLINIC
SOBRIETY CITY LIMITS
CHURCH
CLINIC
MEETING TODAY
CIVIC CLUB
AA GROUP
RECREATION CENTER
OFFICE
ANGER/ RONG RRENT
BRANDYWINE CREEK

(Continued from page 15)

and are, in fact, subject to rather wide differences of opinion. This, however, does not preclude therapeutic effectiveness, providing you keep the following precepts in mind:

As in any disease syndrome, certain basic concepts are helpful. An alcoholic is not someone who drinks "more than I do." For general purposes, alcoholics can be described as those people who drink in a very special way, that is, to excess, compulsively, without control, and self-destructively. The lack of control must be emphasized. Alcoholics have always been subject to condemnation and stigma. They are generally self-condemnatory, self-recriminatory and, with few exceptions, deeply guilty. They resort to numerous rationalizations to explain their alcoholism. The majority, almost without exception, on initial contact, either deny, or at the very minimum, underestimate alcohol as a problem. Even those who verbally beat their chests with alcoholic confessions have hidden doubts of varying degrees as to the causation and extent of their difficulties. The lack of control plus the fact that the alcoholic minimizes his drinking and its effect and will not face the extent of his problems must be considered symptoms of the illness, just as anxiety and depression over a nonexistent heart disease are symptoms of a "cardiac neurosis."

Importance of Attitude

Too commonly the alcoholic is considered consciously vicious, stubborn and self-indulgent, Such a condemnatory attitude on the part of the physician will undoubtedly reduce his effectiveness as a therapist. One does not become angry, irritable and contemptuous toward a patient with an ulcer or heart condition that responds slowly and with difficulty to treatment. By the same token one should not harbor these feelings towards the alcoholic who does not quickly attain sobriety and a well-integrated life.

The general practitioner must be aware of present-day therapeutic approaches to alcoholic problems and the varied facilities available for both helping and treating the alcoholic. He must accept as one of the difficulties the fact that there is no specific successful method of treatment. Consequently, he must not be rigid in demanding one approach. He must not feel defeated if his results are not always what he had hoped for. He must recognize his own limitations and often must play the exceedingly important role of directing the patient to other therapeutic facilities. This in itself may be crucial and will call upon all the doctor's "psychotherapeutic" skill.

Goal Is Sobriety

The immediate goal of therapy is sobriety, and the long-term or ultimate goal is readjustment to a life without alcohol. To achieve this is not easy or simple. The whole patient must be treated—organically and psychologically. By sobriety is meant total and continued sobriety. For him a life without alcohol is extremely difficult. To learn a new way of living in which new interests and activities must fulfill needs and drives that have been dissolved in, or expressed through alcohol becomes, as Alcoholics Anonymous so accurately puts it, "a twenty-four hour a day struggle." It is the physician's task to support through drugs and "psychotherapy" those healthy forces in the patient that are already aligned against alcohol.

Alcoholism may be subdivided into the acute phase with its postintoxication state—"hangover"—and the chronic phase. The postintoxication

stage generally consists of one or all of the following symptoms: psychomotor agitation — the "shakes" — anxiety, depression, gastro-intestinal disturbance and insomnia. Much of this can be lessened in intensity and duration, resulting in an exceedingly grateful patient.

If the general practitioner sees the patient when drinking, or when he is trying to stop, or in the "hangover" stage, there are several tools at his command. In addition to liberal doses of understanding, tolerance and attention, which are indicated in treating all stages of alcoholism, the most easily administered and possibly the most effective drugs are the so-called tranquilizers in sufficient dosage to act quickly. The first dose or two may be administered by parenteral route, followed by adequate and continued oral doses. The reduction of anxiety and agitation, often followed by sleep, produces a tranquil and manageable patient without many of the complications and dangers of other methods.

Dehydration, avitaminosis and other organic problems may also require treatment. A relaxant for agitation, non-barbiturate sedation for insomnia, and cautious use of the amphetamines are other therapeutic aids. This will cover the requirements of most patients.

Use Drugs With Caution

A word of caution is indicated regarding the use of barbiturates and other addictive drugs. The drive of the alcoholic to substitute one addiction for another is an ever-present danger. Barbiturates, if used at all, must be used with great discretion and control, as it is not uncommon to find a sober alcoholic transformed into a barbiturate addict with similar or even greater problems. It is also in this area that the tranquilizers have been such a welcome addition to our armamentarium.

How to get the alcoholic to "let go of the tiger's tail" — to stop drinking — is a great problem which has been the subject of much study and research. Some think the drinking bout must run its course unless one resorts to forceful methods. Certainly this is true in many cases.

Theories Developed

A variety of etiological theories based on physiological and biological changes, such as dysfunction of the hypophysis-adrenal system, dietary and metabolic deficiencies and the like, have been developed with specific treatment methods directed at eliminating these imbalances. Hormones, vitamins, dietary measures and a host of drugs have been suggested and tried. However, no method known today regularly or permanently eliminates the craving for alcohol which persists either consciously or unconsciously in dry alcoholics for a long time and perhaps permanently.

Successful Drug

One widely known drug, disulfiram, which, when combined with small quantities of ingested alcohol produces a severe circulatory reaction and physical discomfort, has been used with considerable success to set up a chemical barrier against drinking. But since this depends on the willingness of the patient to take and continue taking the drug, it has certain obvious limitations. Attempts have also been made to produce an aversion to alcohol — "conditioned reflex treatment." This requires a complicated hospital set-up and personnel and has had only limited use and success. For the general practitioner, the drugs previously mentioned, especially the tranquilizers, would seem to be the

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Here are eleven simple, constructive things you can do to relieve prolonged anxiety and tension.

How To Deal With Your Tensions

BY GEORGE S. STEVENSON, M.D.
And HARRY MILT, M.A.

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Anxiety and tension are essential functions of living, just as hunger and thirst are. Without the experience of anxiety we would not be prepared to avoid or overcome situations harmful to ourselves and our families. Without the ability to tense ourselves we would fall short in emergencies, often to the peril of our lives.

Tension serves, too, as a stimulating source of excitement. It is to gain this kind of pleasure that we play or watch competitive games, pursue adventurous outdoor recreation, and follow drama on stage, screen or television.

Primarily, tensions and anxiety are our self-protective reactions when we are confronted by threats to our safety, well-being, happiness and self-esteem—threats like illness, accidents, violence, financial trouble, trouble on the job, trouble in family relations.

Everybody is confronted by threats: hence, everybody experiences tensions. Yet there are times when we become tense and anxious where no adequate threat exists. This may happen when we have been through a siege of trouble or exhausting work, are worn out and on edge and cannot reason things out or control our feelings as we do when we are rested and in good condition.

Other times this may happen when we are caught up in a conflict which we cannot work out—for example, a conflict between an outraged sense of justice and an urge to bow to the injustice because it is safer to do so; or a conflict between the impulse to do something unethical and the prompting of our conscience, which forbids it.

Very often, too, anxiety and tension may be provoked as a result of some experience in a person's background which has made him particularly sensitive to a threat which may have little effect on others. For example, a man who suffered extreme poverty as a child may react with panic when there is even a casual mention of a possible layoff from the job. Another instance is that of an adult who becomes greatly upset over a minor illness because when he was a child his parents reacted to any illness as though it were a major tragedy.

The average human being has the capacity to live through emotionally upsetting situations—even crises—and to bounce back when they are over. It is important to recognize, therefore, that an occasional bout of anxiety and tension is quite normal, and while it may be unpleasant or even painful, it need not be a

cause for additional concern.

There are, however, some people for whom life is a series of little and big crises. In such instances we may expect more than an occasional passing emotional upset. We may expect to see signs of prolonged and intense anxiety and tension. The time to become watchful, therefore, is the time when emotional upsets come frequently, shake us severely and fail to wear off.

Here are a few simple, ready-to-hand actions which may help you. But remember as you read them that success will not come, even in these, from a halfhearted effort. Nor will it come overnight. It will take determination, persistence and time. Yet the results will certainly be worth your best effort, whether yours is an occasional mild upset, which most of us experience, or one that is more lasting and severe.

1. TALK IT OUT

When something worries you, talk it out. Don't bottle it up. Confide your worry to some level-headed person you can trust; your husband or wife, father or mother, a good friend, your clergyman, your family doctor, a teacher, school counselor, or dean. Talking things out helps to relieve your strain, helps you to see your worry in a clearer light, and often helps you to see what you can do about it.

2. ESCAPE FOR A WHILE

Sometimes when things go wrong, it helps to escape from the painful problem *for a while*: to lose yourself in a movie or a book or a game, or a brief trip for a change of scene. Making yourself "stand there and suffer" is a form of self-punishment, not a way to solve a problem. It is perfectly realistic and healthy to escape punishment long enough to recover breath and balance. But be prepared to come back and deal with your difficulty when you are more composed, and when you and others involved are in better condition emotionally and intellectually to deal with it.

3. SHUN THE "SUPERMAN" URGE

Some people expect too much from themselves, and get into a constant state of worry and anxiety because they think they are not achieving as much as they should. They try for perfection in everything. Admirable as this ideal is, it is an open invitation to failure. No one can be perfect in everything. Decide which thing you do

well, and then put your major effort into these. They are apt to be the things you like to do, and hence those that give you most satisfaction. Then, perhaps, come the things you can't do so well. Give them the best of your effort and ability, but don't take yourself to task if you can't achieve the impossible. Give yourself a pat on the back for the things you do well, but don't set yourself records to break in everything you do.

4. TAKE ONE THING AT A TIME

For people under tension, an ordinary work load can sometimes seem unbearable .The load looks so great that it becomes painful to tackle any part of it—even the things that most need to be done. When that happens, remember that it's a temporary condition and that you can work your way out of it. The surest way to do this is to take a few of the most urgent tasks and pitch into them, one at a time, setting aside all the rest for the time being. Once you dispose of these you'll see that the remainder is not such a "horrible mess" after all. You'll be in the swing of things, and the rest of the tasks will go much more easily. If you feel you can't set anything aside to tackle things this sensible way, reflect: are you sure you aren't overestimating the importance of the things you do—that is, your own importance?

5. GIVE THE OTHER FELLOW A BREAK

When people are under emotional tension they often feel that they have to "get there first" —to edge out the other person, no matter if the goal is as trivial as getting ahead on the highway. If enough of us feel that way—and many of us do—then everything becomes a race in which somebody is bound to get injured—physically, as on the highway, or emotionally and mentally, in the endeavor to live a full life. It need not be this way. Competition is contagious, but so is cooperation. When you give the other fellow a break, you very often make things easier for yourself; if he no longer feels you are a threat to him he stops being a threat to you.

6. MAKE YOURSELF "AVAILABLE

Many of us have the feeling that we are being "left out," slighted, neglected, rejected. Often, we just imagine that other people feel this way about us, when in reality they are eager for us to make the first move. It may be we, not the others, who are depreciating ourselves. Instead of shrinking away and withdrawing, it is much healthier, as well as more practical, to continue to "make yourself available" — to make some of the overtures instead of always waiting to be asked. Of course, the opposite of withdrawal is equally futile: to push yourself forward on every occasion. This is often misinterpreted and may lead to real rejection. There is a middle ground between withdrawal and pushing, Try it.

7. DO SOMETHING FOR OTHERS

If you feel yourself worrying about *yourself* all the time, try *doing* something for *somebody else*. You'll find this will take the steam out of your own worries and—even better—give you a fine feeling of having done well.

8. SCHEDULE YOUR RECREATION

Many people drive themselves so hard that they allow themselves too little time for recreation—an essential for good physical and mental health. They find it hard to make themselves take time out. For such people a set routine and schedule will help—a program of definite hours when they will engage in some recreation. And in general it is desirable for almost everyone to have a hobby that absorbs him in off hours—one into which he can throw himself completely and with pleasure, forgetting all about his work.

9. GO EASY WITH YOUR CRITICISM

Some people expect too much of others, and feel frustrated, let down, disappointed, even "trapped" when another person does not measure up. The "other person" may be a wife, a

husband or a child whom we are trying to fit into a preconceived pattern—perhaps even trying to make over to suit ourselves. Remember, each person has his own virtues, his own shortcomings, his own values, his own right to develop as an individual. People who feel let down by the shortcomings (real or imagined) of their relatives, are really let down about themselves. Instead of being critical about the other person's behavior, search out the good points and help him to develop them. This will give both of you satisfaction, and help you to gain a better perspective on yourself as well.

10. WORK OFF YOUR ANGER

If you feel yourself using anger as a general way of behavior, remember that while anger may give you a temporary sense of righteousness, or even of power, it will generally leave you feeling foolish and sorry in the end. If you feel like lashing out at someone who has provoked you, try holding off that impulse for a while. Let it wait until tomorrow. Meanwhile, do something constructive with the pent-up energy. Pitch into some physical activity like gardening, cleaning out the garage, carpentry or some other do-it-yourself project. Or work it out in tennis or a long walk. Walking the anger out of your system and cooling it off for a day or two will leave you much better prepared to handle your problem intelligently and gainfully.

11. GIVE IN OCCASIONALLY

If you find yourself getting into frequent quarrels with people, and feeling obstinate and defiant, remember that that's the way frustrated children behave. Stand your ground on what you know is right, but do so calmly and make allowance for the fact that you *could* turn out to be wrong. And even if you're dead right, it's easier on your system to give in once in a while. If you yield, you'll usually find that others will, too. And if you can work this out, the result will be relief from tension, the achievement of a practical solution, together with a great feeling of satisfaction and maturity.

Here is the truth about ---

Alcoholism and Skid Row

BY ROBERT STRAUS, Ph.D

The Homeless Man presents unique problems in rehabilitation.

About fifteen years ago most persons were under the impression that alcoholism was primarily a problem of the skid row derelict. We assumed that all derelicts were alcoholics and that the problems were almost synonymous. Although each of us as individuals may have known one or two alcoholics who lived up the street, who were very fine people and who were maintaining positions of status and stability in the community, we considered them the exceptions. They weren't really alcoholics. It was very comforting to think of alcoholism as something that we could look down upon, reject, deny the reality of, or push aside.

Until recently, the public provisions that were made for alcoholism were aimed primarily at the derelict population. We had the municipal shelter programs; our charitable missions; we had our jails which were and still are primarily filled with derelict men who are usually arrested for drunkenness or for some offense which is closely associated with intoxication. And then we had our mental hospitals which were and still are crowded in part with problem drinkers who may stay for six months or nine months, taking a bed that could and should be used for some other type of patient and then go out only to enter, perhaps, another mental hospital or a jail.

There were two developments starting in the late 1930's and beginning to take impetus in the late 1940's which were identified with a gradual change in our conceptions of alcoholism.

The first of these was the remarkable phenomena, *Alcoholics Anonymous,* and the second the idea that perhaps the problems of alcoholism could be more effectively and more economically approached through the use of an *out-patient community*

Reprinted from a report of the First Annual International Institute on the Homeless Alcoholic, held in Detroit, Michigan, September, 1955

clinic.

We all know the story of the growth, the development and emergence of the AA program. Of particular significance to us here is the realization that many of the men and women who were achieving sobriety and enjoyment of life through the Alcoholics Anonymous program, were not homeless derelicts.

Patients Were "Respectable"

Curiously, the early out-patient clinics for alcoholics were often established with the intention that they would relieve the court and the jail of their problem of handling the homeless alcoholic. However, they soon found that they were dealing with quite a different segment of the population. Frequently their patients were men and women who were married and living with their families, had histories of steady employment in positions requiring skill and responsibility and were at least partly integrated as members of their communities. Only with the emergence of Alcoholics Anonymous, the growing impact of public education and the removal of stigmas about alcoholism, and the establishment of specialized clinical facilities where alcoholics of this type could seek help, has it become possible to identify this segment of the alcoholic population. These men and women who still possess certain social assets often present the most favorable prognosis and readjustment potential.

The homeless man who has experienced years of social isolation bereft of normal experiences of personal interaction is often lacking in many of the basic techniques for getting along with other people. The treatment of such a patient is complicated by the fact that, even if he learns to live without alcohol, his life has no meaningful orientation. Furthermore, the thought of adjusting to life in normal society suggests many strange and frightening experiences made all the more painful if they must be met without the anxiety-depressing effects of alcohol. Indeed, usually there seems to be far greater incentive for the patient to seek an anesthetic from the realities of his marginal existence.

On the other hand, psychological and physiological factors being equal, prognosis for recovery tends to be favorable when patients have families, have lived or still live with other people in regularly established households, have permanent ties with a community, or have held forms of stable employment. The therapist is at a distinct advantage when his patients have retained at least some ties with the normal social institutions and with common interpersonal relationships; when, in short, the positive aspects of no longer drinking are supported by the incentives of achieving social and psychological integration and adjustment. Furthermore, the man with social assets can draw on activities and companionship to help him get over periods of crises in his recovery process. The importance of such support has been dramatically illustrated by the Alcoholics Anonymous program.

Patients Differ

Recently studies have revealed that the majority of the patients who are seen in modern alcoholism treatment facilities differ markedly from the stereotyped homeless alcoholic in the number of social homeless which they can muster. At the same time, studies of the homeless man population reveals dominant drinking patterns and motivations which are distinctly different from the clinical concept of alcohol addiction.

These conclusions can be illustrated by summarizing studies of two different groups of alcoholics which will be designated as "clinic patients" and "homeless men."

Data on marital status provide a striking contrast between these two groups. Of the homeless men, a little more than half never married; the rest were either widowed, divorced, or separated from their wives. Among the clinic patients, only 20 percent had never married; this is to be compared with an expectancy of 21 percent shown by age-adjusted census data for all urban males. Half of the clinic patients (51 percent) were married and living with their wives as compared with an expectancy for the total population of about 70 percent. Among the clinic patients who had married, 36 percent had become divorced, separated or widowed. This rate greatly exceeds the age-adjustment expectancy of 9 percent for the total population. But when compared with a marriage fatality rate of 100 percent for homeless men, the marriage stability of the clinic patients is remarkable.

Records of employment reveal a similarly striking contrast. The homeless men were all without any kind of employment when interviewed. Most had been without a steady job for many years or had never experienced anything but casual employment. Fully half had never held any type of job above the level of unskilled laborer. Only 10 percent had been employed in white-collar, managerial, or professional jobs.

In contrast, it was found that fully 62 percent of the clinic patients were steadily employed when first seen in the clinics. Three out of five had histories of steady employment for at least three years. Eight percent had records of jobs involving definite status, skills or responsibilities.

Clinic Patients Contrasted

Three-fourths of the clinic patients were living in established households; the homeless men obviously had no residential ties. Most of the clinic patients (90 percent) had lived in their present town of residence for at least two years; the homeless included a large number of transients. The clinic patients were on the whole a much younger group. Nearly half (46 percent) were under forty years of age; only one out of five was fifty or over. Among the homeless, just the reverse was found — only one out of five was under forty while half were fifty or over.

Although the clinic patients and a majority of the homeless men are appropriately classified as alcoholics, it is obvious from the few data cited here that these groups differ widely in the relative extent to which they have maintained stability in their basic social roles.

Differences between clinic patients and homeless men were not restrict-

ed to social characteristics. There were also marked variations in the dominant patterns of drinking manifested by these two categories of alcoholics. Clinicians are generally agreed that there is no specific alcoholic archetype. However, the identification of at least two distinct patterns of alcoholic behavior has emerged independently from several sources. The Subcommittee on Alcoholism of the World Health Organization has suggested that these categories be called "addictive drinkers" and "habitual symptomatic excessive drinkers."

For most *addictive* drinkers there is an impulsive drive to attain a maximum degree of intoxication from alcohol on nearly every drinking occasion. These people are seeking a peak effect from alcohol which the nonalcoholic has never experienced. Usually, once they start drinking they are unable to control themselves until this peak has been attained. The addictive drinker with a five-dollar bill will probably spend it for some form of beverage which will provide the greatest amount of alcohol in the quickest and most concentrated form, for in this way he can most successfully raise his level of alcohol blood concentration.

Addiction Common

The addictive type of drinking pattern is most characteristic of patients seen in community alcoholism clinics. While there are some addictive drinkers among homeless men, it has been observed that a significant segment of these alcoholics fit the category described by WHO as *habitual symptomatic excessive drinkers.* They place their greatest emphasis on the duration of their drinking rather than on its intensity. They appear to be seeking a plateau. Given a five-dollar bill these men would not be likely to think how quickly they could achieve a state of peak intoxication, but instead would plan their drinking so that they could maintain a limited level of effect from alcohol for as long a period of time as possible. These plateau drinkers are seeking to maintain a limited alcohol-induced oblivion from the life around them. While under the effect of alcohol the vast gap between their own way of life and the rest of society seems less pronounced. They can acquire a feeling of well-being and accomplishment in the midst of poverty and degradation. They can overlook their lack of material possessions and forget their loneliness. Drinking also provides a certain status in settings where the nondrinker is rare and may even be considered queer and avoided by others.

Alcohol Means Life

Most of the homeless men studied do not appear to feel that they have a drinking problem. Many recognize quite frankly that alcohol is providing them with a means of going on from day to day and facing life. About 70 percent of one group of about 200 men stated with apparent sincerity and frankness that they desired no change in their drinking practices. Change for these men is frightening and full of insecurity and anxiety. The basic problem for a large segment of these men is one of dependency, not alcohol, and it goes far back in their lives.

Half of the men seen in the homeless-man studies had lost one or both parents by death before they reached the age of twenty, and the homes of many of them were disrupted by other factors. Most had left their parental family in their late teens and sought a substitute home in some employment situation providing board and quarters. Some joined one of the peacetime military servi-

ces or the merchant marine. Not a few served with the Civilian Conservation Corps during the depression of the thirties. In all of these situations they found what can be called a highly institutionalized way of life .That is, the basic necessities of food, clothing, and shelter were provided for them, there was a fairly regular routine, and demands on individual initiative were at a minimum.

Adjustment Difficult

After a few years of institutionalized living at the crucial age period of perhaps 17 to 24 these men found it difficult to adjust to a more independent mode of living in a community. Having spent a number of years in a protected environment they had failed to learn many of the simple amenities for getting along in a normal society. Even the requirements involved with meeting their needs were wrought with insecurity. Furthermore, their contemporaries had married, become regularly employed, developed new interests, and progressed far beyond them.

The so-called skid row areas of our larger cities actually serve as a form of pseudo-institutionalized setting for these men. Religious and public charities provide facilities for meeting basic needs, and society puts no demands on its skid row inhabitants. Thus, it is suggested that the homeless man has been caught in a spiral of ever-increasing dependency in which alcoholism of a non-addictive plateau variety is a form of functional adjustment to his routine and low level of existence. When institutionalized living was studied, the histories of 93 percent of the homeless groups revealed such a pattern; for at least 70 per cent this pattern appeared dominant.

A clarification of differences such as those concerning the drinking patterns of homeless men and the social characteristics of alcoholics coming to community treatment facilities is essential if effective measures to deal with the problems are to be adapted. It is significant that the establishment of clinic facilities has followed recognition of the fact that existing facilities such as jails, shelters, and mental hospitals cannot meet the problem. Then, when the clinics were in operation it was found that these too do not meet the problem as it had been defined, but a previously unrecognized aspect of the problem. Upon further study there followed a reconceptualization of that aspect of the problem particularly concerned with the derelict. Out of this are now developing suggestions for rehabilitation which aim to meet dependency as a prerequisite to any shift in drinking pattern.

Program Pointers

(Continued from page 4)

which to reduce our printing costs, we decided to take a survey of INVENTORY's out-of-state subscribers, hoping to eliminate duplications and incorrect addresses. Our survey has met with great response and within a few weeks we will begin surveying our North Carolina subscribers. These surveys will decrease our mailing list for the time being, but it is expected that within a few months, the list will approach and exceed its former size. In the meantime we hope the savings resulting from our smaller list will help us in restocking other literature.

The Editor's Page

(Continued from page 3)

who do not concur in Dr. Williams' genetotrophic theory. Notable among those who disagree are Drs. Greenberg and Lester, research physiologists on the staff of the Yale Center of Alcohol Studies. Their published studies have cast doubt upon the research design of the original animal experiments upon which Williams has based his nutritional theories.

Another dissenting voice is that of Dr. Ruth Fox, distinguished New York psychiatrist, who incidentally spent the first five years of her medical career as a research fellow in biochemistry. In her recent book on alcoholism, Dr. Fox says, "Alcoholism is a neurosis . . . Despite all the efforts to demonstrate that alcoholism results from some constitutional deficiency, despite all the hopes and wishes of the alcoholics themselves that somehow they may escape from the stigma of the neurosis, alcoholism is a mental illness."

Organized Philosophy

The vast majority of organized alcoholism programs both state and local, have been set up to combat alcoholism as an emotional illness. This working philosophy was arrived at only after the most careful and arduous study of existing research data in the area of alcoholism causation. When all the evidence is weighed, the theory that the causes may be found in the individual personality, rather than in his tummy, his glands or his liver, remains the most acceptable.

In short, we feel that we are still in good company in promoting the idea that alcoholism is an emotional illness. We have seen nothing yet that persuades us to abandon the philosophy of alcoholism treatment and prevention upon which this Program was founded and under which we have been operating for the past eight years.

Wishful Thinking

If the truth were told, we wish alcoholism were an illness which could be controlled in the relatively simple manner which Dr. Williams proposes. We would like to be able to tell an alcoholic, for example, that he is suffering from an inherited nutritional deficiency rather than explain to him that he is emotionally sick. How much simpler it would be to say to parents asking how to immunize their children against alcoholism, "Give them Dr. Williams' nutritional tests," instead of the more complex answer, "Improve your day to day relationships with your children." Our clinical director would find his job infinitely more rewarding if, instead of prescribing an anxiety-producing course of group therapy for his patients he could prescribe massive doses of vitamin supplement designed to correct their nutritional deficiencies..

Would Sobriety Last?

Yes, our job would be much easier and bring us many more immediate rewards if we could accept Dr. Williams' theory. But how many alcoholics would be helped to lasting sobriety through this new approach? How many cases of alcoholism would be prevented? We're not sure. Perhaps some. Perhaps many. Maybe none at all.

We hope Dr. Williams will be able to prove that his idea is better. But until he does, we don't think it is fair to hold out to the public this panacea of a quick, easy "vitamin cure" for alcoholism. — GHA

The Woman Alcoholic

(Continued from page 9)

mental pressures "play a more decisive precipitating role in women's alcoholism."

The comparison of the State Farm women with the outpatient women revealed many sharp differences. The committed women came from a lower socio-economic background, were younger and less well educated. They had experienced a somewhat higher incidence of marital disruption and, perhaps more important, their marriages were marked by even greater instability and conflict than those of the outpatient women. The State Farm women were more frequently married to men much older than themselves. As might be expected, quite a few had been involved in offenses against the sex mores, a comparatively rare occurrence among the clinic women.

The State Farm women lost control over their drinking earlier than the outpatient women but fewer of them were lone drinkers. Drinking was not usually the primary or central problem for the State Farm women. It complicated their already chaotic lives, but alcoholism was usually superimposed on their other problems.

Two Groups

Taken together, Lisansky's findings suggested that among women alcoholics at least two sub-groups can be differentiated. The first is typified by the woman seen in the outpatient clinics who, on the whole, exhibits a fairly high degree of social integration. She manages to stay out of the public view and out of difficulties with the community These might be called the "respectable" women alcoholics. The second is typified by the State Farm woman with a history of conflict with the law, inability to hold a job and failure to cope with environmental problems even before the onset of problem drinking. These women, a decided minority, are perhaps more akin to the "homeless man" who has been described as a non-addictive pathological drinker. In any case, it is no more possible to draw a single portrait of the alcoholic woman than of the alcoholic man. By the same token, no single program of treatment can be expected to work for all alcoholic women.

The Generalist's Role

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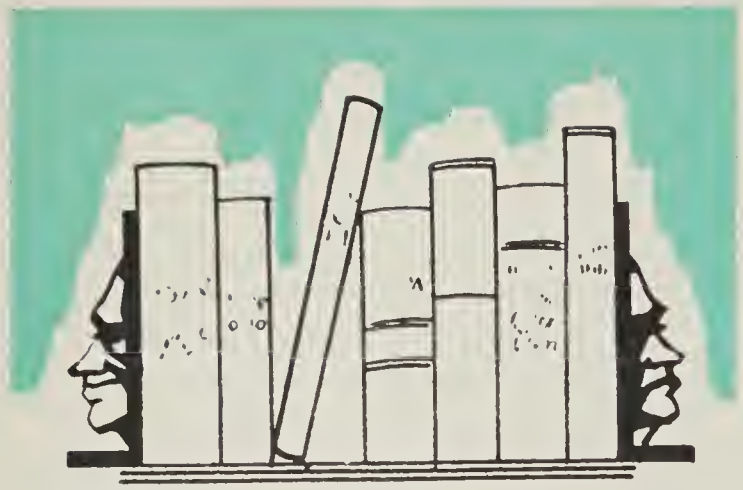
treatment of choice.

However, no matter what type of medical or drug therapy is recommended, the consensus is that psychotherapy in some form is necessary as a conjunctive therapy. Psychotherapy (and the term is used in a broad sense), group therapy of various kinds or Alcoholics Anonymous should be recommended. This combination of organic treatment and psychotherapy is more effective than either alone. Although psychoanalysis, as distinct from psychotherapy, offers a rational, developed theory of the dynamics of alcoholism and addiction, it has not been too successful. Few cases undergo and continue in psychoanalysis.

If the general practitioner can help sober a patient, alleviate some of the postintoxication symptoms, and direct him to psychotherapy, Alcoholics Anonymous, or other sources to help him maintain his sobriety, he can be of considerable help to the more than four million adults in the United States who have alcoholic problems.



Books of Interest

MY FATHER, MY SON

BY EDWARD G. ROBINSON, JR.

Frederick Fell, Inc.
New York
316 pp. $3.95

"In Beverly Hills we had them all—nail biters and crib-rockers, thumb-suckers and head-bangers. I was a nail-biter myself. I still am."

Thus begins the autobiography of Edward G. Robinson, Jr., "My Father, My Son." with collaborator, William Duffy.

Eddie Robinson, born in 1933, has probably done more in his 25 years than most people do in 50. He's been in jail several times, sued once or twice, married once, divorced once, father of one daughter, patient of 8 to 10 different psychiatrists. He's been broke more often than not, began his drinking career at the age of 3, and was called a full-fledged juvenile delinquent before he was even 18. He has quite a story.

Son of the Great Man, Eddie Robinson, Jr., writes that he never had a chance. Alternately adored and ignored by his famous parents, raised by nurses and governesses, spoiled rotten by everybody, he grew up with an exaggerated idea of his own value and reports he "raised hell" as a way of crying to his parents, "Why don't you love me?" and then, "See what a big man I am. I don't need you."

Raised among Hollywood greats, Eddie was allowed to do as he pleased from the start. Although blessed with dramatic acting ability, he never used it to his advantage. So mixed up, confused, and frustrated, he took his revenge on his parents and Hollywood by running up terrific bills at clothing stores, drinking and fighting all over town (at his father's expense), taking sleeping pills and then calling up a friend to tell him what he'd done so he'd be sure to get to a hospital in time.

He was married at 18 to a North Carolina girl turned New York model and then he became a father. "For years, you're looking for a Daddy and then one day you end up being one. For years you're at war with your parents, and then you discover you're about to be a parent yourself."

But their little daughter was not enough to mend a torn marriage and Nancy and Eddie were divorced. And now Eddie, who has taken 316 pages to tell you how neglected he was and how mean his parents were, is doing the same thing to his daughter. The pattern is repeating itself and the sad part of it is that Eddie is still so wrapped up with himself and his problems, that he has no idea what he is doing to his child.

"My Father, My Son" is supposed to give great insight into the character of an alcoholic. But it fails. The only insight and understanding Eddie Robinson, Jr. has is what he's heard he ought to have. The book, though poignant at times, leaves the reader with the distinct and sad impression that whatever Eddie Robinson has been through, he will go through again, unless somewhere he is able and willing to find the help he needs.—*C. Cheney*

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

North Carolina State Library
Raleigh
N.C. Doc.

MARCH-APRIL, 1958

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

VOLUME VII NUMBER 6

MARCH-APRIL, 1958

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 15 West Jones St., Raleigh, North Carolina.

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Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH: Final plans are now in the making for the 1958 Summer Studies on Facts About Alcohol, sponsored each year by the NCARP in conjunction with the participating colleges. Dates and places for the summer studies are as follows: June 3-13, East Carolina College, Greenville. June 10-20, North Carolina College, Durham. June 23-July 4, Woman's College, Greensboro. June 23-July 5, A & T College, Greensboro.

The summer studies are designed especially for teachers and prospective teachers who are interested in alcohol and alcoholism education. North Carolina teachers may apply for admission by writing directly to the Registrar of the college they wish to attend.

NEW HAVEN: The Publications Division of the Yale Center of Alcohol Studies has announced the launching of a new series of book-length monographs, to be known as the Monographs of the Yale Center of Alcohol Studies. Works in this series report the results of original research in any of the scientific disciplines, whether carried out at Yale or elsewhere and will be published in collaboration with the Free Press of Glencoe, Illinois.

RALEIGH: The NCARP is offering scholarships for physicians, caseworkers, nurses, psychologists, clergymen and educators to the Yale Summer School of Alcohol Studies, to be held this summer from June 29 through July 24, at New Haven, Connecticut. Scholarships will cover the cost of tuition, fees, room and board. Those members of the professional groups listed above who wish to apply for a scholarship may write the NCARP, 15 West Jones Street, Raleigh.

NEW YORK CITY: The National Council on Alcoholism held its annual conference March 26, 27, and 28, at the Statler Hotel in New York. The conference featured two full days of workshops on techniques used by local affiliates and a one-day session on the Homeless and Institutional Alcoholic. Featured speaker was James F. Oates, President of the Equitable Life Insurance Society and member of the Sponsoring Committee of the Chicago NCA affiliate.

GREENSBORO: The 1958 Nurses' Institute will be held in Greensboro Wednesday April 30, as part of "Alcoholism Week." The Institute, sponsored by the three state nursing associations and the NCARP, will include talks and panel discussions by experts in the field of alcoholism and nursing. For details, see the ad for the Institute further on in this issue.

Grateful Patient

I am a patient at the Alcoholic Rehabilitation Center at Butner. I am going home Friday as my 28 days will be up. I think this is the only place that I know of for anyone who has an alcoholic problem. I also think that there are other problems that people have which can be helped here at Butner. I would appreciate it very much if you will send a copy of "The New Cornerstones" to my wife.

I have enjoyed my stay here and I know that when I leave, I will certainly start out with a new perspective towards life. I think that Mr. Barham, the attendants and the entire staff are doing wonderful work at Butner.

Name Withheld

"Inventory" Praised

Ever since you have been publishing "Inventory" you have been mailing it to me and I wish to tell you how much I have appreciated it. It has been a great assistance to me and my work with alcoholics. I have passed the pamphlet along to different members in AA.

You would be interested to know that on December 20, 1957, I rung up 18 years of sobriety without a single slip.

A Recovered Alcoholic

A Thank You

I have received a copy of Alcohol Education Reference Aid for Teachers which you sent recently. I find it will be very helpful to me in my work with teen-agers. It is one of the best I have read to date, informative, instructive and interesting. Thank you for making this text available to me.

Mrs. J. V. Snyder, Counsellor
Alcoholism Unit
Department of Public Health
Philadelphia, Pennsylvania

Advice Wanted

We are very much in need of pamphlets that would pertain to alcoholism as it affects business and industry. The specific purpose for which these pamphlets would be used is the Greater Charlotte Occupational Health Conference to be held March 13, 1958.

Please give us your advice about literature we might obtain for this purpose.

Mrs. Alan Burks, Vice President
The Mental Health Association of
Charlotte and Mecklenburg County

Yale Alumnus

As an alumnus of the Yale School on Alcohol Studies of 1957, I am writing you to thank you for making it possible for me to attend this very helpful and very authentic study session. I regard it as one of the most helpful and one of the most stimulating educational experiences of my career.

Thomas A. Bland
Southeastern Baptist
Theological Seminary
Wake Forest, N. C.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

NORTH CAROLINA law, as in all states in the union, requires that instruction about alcohol be included in the public school system's course of study. In the past this law left much to be desired as far as professional educators were concerned, particularly those concerned with alcohol and problems associated with alcohol.

The teachers had poorly prepared material to use in the classroom; much of it, in fact, contained more mis-information than information. The school administrators were hesitant to include alcohol education in the classrooms because of the ire which might be incurred in the community. Teachers, too, were reluctant to teach information about alcohol, because of its controversial nature and their lack of special training. Since the schools and their teachers were not sure of their ground, they thought it easier and wiser to neglect the alcohol education law. Under the circumstances, this attitude was quite understandable.

New Attitudes

But now, this situation no longer exists. Everywhere new attitudes about alcohol education are being found. Parents are interested in seeing that their children receive objective, scientific data about alcohol and alcoholism, just as they are interested in a scientific treatment of sex education in the classroom. They want their children to know the *facts*, taught to them without bias or moralizing. The school administrators and the teachers are awakening to the real need for alcohol education; laws concerning alcohol education are being rewritten, being brought up to date. Disappearing from the laws are those sections or phases which told the educators at which grade level alcohol education should be taught and what the content of the course should include.

I would like to quote you the revised law which was passed in 1955.

"There shall be organized and administered under the general supervision of the State Superintendent of Public Instruction a comprehensive program of physical education and of health education including scientific instruction in the subject of alcoholism and narcotism. It shall be the duty of teachers and principals in connection with this program to screen and observe all pupils in order to detect signs and symptoms of deviation from normal and to record the results of their findings in accordance with the established policies and procedures and upon blanks furnished for this purpose."

Please notice that the law says *scientific* instruction and the requirements for the times, places, manner and degree of alcohol education is left to the educators who

(Continued on page 31)

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INVENTORY

MARCH-APRIL, 1958

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

HOW TO RECOGNIZE AN ALCOHOLIC

By CLIFFORD J. EARLE

IT usually is not easy to recognize an alcoholic. One can spot a drunk in the advanced stages of alcoholism readily enough, but the earlier stages of the affliction often escape detection. The preliminary and early symptoms are sometimes unnoticed in a person who is crossing over from uncomplicated drinking to alcoholism, even by his friends and members of his family. Not everyone who drinks heavily is an alcoholic.

Ever wonder who was the alcoholic and who was the heavy drinker? Read this article and you'll find out.

Some persons drink to excess because of stupidity or foolishness, or because they think it is the smart thing to do. Whatever the reason, these people can stop drinking if

From "How To Help An Alcoholic" by Clifford J. Earle. Copyright 1952 by W. L. Jenkins. The Westminster Press. Used by permission.

they want to.

An alcoholic may be described as a person with an unmanageable craving for alcohol. The outstanding criterion of the disorder is his inability, without help, to achieve permanent sobriety. He may wish to stop drinking, but he is obsessed with an unconquerable fear that without alcohol life would be impossibly difficult.

A major characteristic of alcohol addiction is the loss of control in the drinking situation. In time the alcoholic's ability to manage his drinking disappears completely. So long as he stays away from alcohol he has no difficulty, but when he begins to drink he is unable to limit himself to a moderate amount. For the time being, alcohol becomes the most important thing in his life. A spree of a day or a week or a month of uncontrolled drinking follows, and after that the hang-over.

A second important characteristic of alcoholism is the progressive nature of the disorder. The symptoms are graded. They increase in severity from stage to stage. The affliction begins as a hardly noticeable deviation from customary drinking. In time a series of more obvious and increasingly objectionable features of the disorder make their appearance. Then follow years of progressive deterioration that involves all areas of the victim's life.

Motivation

A third characteristic of alcohol addiction has to do with the motivation for drinking. The alcoholic drinks because he likes what alcohol does for him. He finds that it makes life seem simpler and easier, and he uses it for that purpose. Alcohol gives him immediate though temporary relief from the burden of his problems but really makes life more difficult. He ignores all this, however, as he seeks through alcohol to ease his discomfort and tension. He may not like liquor—many alcoholics don't—but he thinks he needs it in order to live.

Certain telltale symptoms in the realm of drinking behavior are sometimes useful in helping one to tell whether or not a person under observation is an alcoholic.

An Indicator

One indicator is the "blackout", described as temporary amnesia related to a period of intoxication. Experiencing a "blackout" is not to be confused with "passing out." A person has a "blackout" when, for example, he wakes up in the morning after a party and cannot recall where he has been or what he has done after the first few drinks. At the time, of course, neither he nor those around him are aware of anything unusual. Only later does the victim of the "blackout" realize that he has "drawn a blank." "Blackouts" are not limited to alcoholics. Even a moderate drinker who gets drunk only once in his life may experience a "blackout" on that occasion. Among alcoholics, however, "blackouts" are an almost universal occurrence. Usually they begin to happen in the very early stages of alcohol addiction. In the later stages, they are often a frequent occurrence. Since a "blackout" is really a reaction to intoxication, it should not be regarded as evidence of alcoholism, but rather as a danger signal or a possible symptom.

By many little signs a potential alcoholic will reveal to an informed observer that he is beginning to lose control of his drinking. He may promise his wife that he will limit himself to two drinks in an evening, but by means of various subterfuges and excuses he will manage to have many more. He may take several

quick drinks in the kitchen on the sly while pouring refreshments for guests. He may start drinking before the guests arrive and keep well ahead of everyone else in the consumption of alcohol during the evening. He may create a scene in order to have a reason for drinking more than he planned or promised to drink. However he manages it, when a person in a drinking situation intends to take a couple and winds up cockeyed, and does that persistently, he has crossed over into the early phase of alcoholism.

Early Stages

In the early stages of addiction, alcoholics generally make several real and sincere efforts to bring their drinking under control. A familiar technique, tried by a great majority of alcohol's victims, is "going on the water wagon". Sometimes the "water wagon" represents an attempt to stop drinking entirely. Usually, however, the alcoholic has in mind a limited period of time during which he tries not to drink. After a frightening "blackout", for example, he may venture "to lay off liquor for a couple of months" or "to quit drinking until Christmas." The "water wagon" and other forms of drinking control attempted by an alcoholic reveal that he is beginning to realize that his drinking is getting to be a problem. "Going on the wagon" is not to be regarded as a symptom of alcoholism, but rather as a clue to what is going on in the mind of a person under observation.

The "morning drink" as a regular occurrence reveals usually that a person has lost control not only in the drinking situation but also over the occasions for drinking. Upon waking in the morning an alcoholic may experience some hangover effects from yesterday's drinking—nervousness, tremor, nausea, remorse, depression. These he must quickly anesthetize with alcohol if he is to be in shape for the day. So the "morning drink" becomes for him a necessity. And more, it proves to the alcoholic that he really needs alcohol in order to be normal. Many students of the alcohol problem regard the "morning drink" as one of the cardinal signs of alcoholism. It is a symptom appearing in the drinking behavior of nearly all alcoholics.

A "bender" is described as "staying drunk for more than a day without regard for your work or your family or anything else." Occasionally a non-alcoholic heavy drinker may go on a "bender" as his way of reacting to a crisis or disappointment. Periodic "benders", however, are a drinking behavior that is usually identified with alcoholism. They appear as a somewhat advanced symptom in the drinking histories of a large majority of alcoholics. They may happen at irregular intervals ranging from a few weeks to several months. As the affliction progresses, drinking sprees are likely to occur more frequently, to last longer, and to increase in severity. Periodic "benders" are regarded by many authorities as a major manifestation of the middle phase of alcoholism, intermediate between a primary phase characterized by loss of control, and a more advanced phase in

which the alcoholic drinks to live and lives to drink.

Two other manifestations of an alcoholic's condition often appear to members of his family and to others in position to observe him closely.

First, a genuine alcoholic is usually worried about his drinking. This distinguishes him from the average heavy drinker who deliberately uses alcohol in excessive amounts and likes what happens to him. The alcohol addict drinks because he craves alcohol, and is not pleased when his drinking leads to a variety of difficulties. He cannot help noticing that he is different from his friends in the way he needs and uses alcohol. He knows that something is wrong. He insists that it is all right, but really is worried. His anxiety often leads him to try to limit or control his drinking. He may decide, for example, to drink only before dinner. Or he may switch from one type of alcoholic beverage to another. Or he may temporarily "go on the wagon."

Secondly, his drinking in time interferes with his eating. This happens because the alcoholic is more interested in alcohol than in food. Moreover, heavy drinking may affect the taste buds so that all food "tastes like hay." His appetite all but disappears, because alcohol, with its high calorific content, satisfies most of the immediate energy requirements of the body. The failure of the alcoholic to eat right deprives the body of many of the foods that are essential to health—vitamins, carbohydrates, fats, proteins, certain minerals. These lacks in time result in actual body damage. The aging process is accelerated. Many of the physical and nervous disorders associated with chronic alcoholism, even cirrhosis of the liver and delirium tremens, are now suspected to be nutritional deficiency diseases.

Sometimes an identifying feature of alcoholism is the way it causes trouble. Excessive drinking of the kind an alcoholic does is bound to produce a persistent and growing problem in one or more areas of his life.

Most often affected, and often more seriously, is the home life of the alcoholic. His unpredictable and usually inconvenient behavior while under the influence of liquor places a heavy strain upon family ties. Domestic life is sometimes reduced to a succession of quarrels and scenes which drive the offender into either angry resentment or anguished remorse. It is not remarkable that alcoholism is an important factor in the breaking up of many homes.

Money Troubles

Money trouble is a familiar alcoholic complication. The cost of liquor is such that a heavy drinker often spends as much as a hundred dollars a month for his beverages. If he is not an alcoholic, the chances are that he will spend only as much as he can afford. If he is an alcoholic, however, he will get his liquor even though he cannot afford it. In time his drinking will have an adverse effect upon his income, producing further financial complications. Savings are spent, insurance premiums go unpaid, jewelry and clothing are pawned, living standards go down, all because alcohol has become for its victim the most important thing in life.

Persistent and deepening problems may appear also in the social life of the alcoholic when he offends and loses his friends, in his business or professional life when he becomes erratic and inefficient in handling his work and finally loses his job.

(Continued on page 30)

An Inventory Feature

Nurses' Forum On Alcoholism

THE NURSE
and the Alcoholic Patient

By GRACE M. GOLDER

As the nurse has grown in stature, she has become a valuable part of the health team. In the treatment of alcoholism it is thus important that she understand the patient and the illness.

Condensed, with permission from the Am. Journal of Nursing, April 1956

MANY nurses can remember the time when their function was envisioned purely in terms of the patient's bedside, either in the home or in the hospital, in this country or abroad, or as wartime "angel of mercy" ministration to the sick and wounded victims of battle. Nursing skills and procedures were limited then, and were far less complicated than they are at present. The nurse was particularly the handmaid of the physician, carrying out his professional orders. She had chosen her career because she wanted to help people, to "do things for them."

It is only as nursing has matured professionally that the nurse has progressed from the concept of merely doing things *for* the patient to doing things *to* him, and finally to the present stage of doing things *with* the patient, *with* his family and *with* other members of the health team. One mark of this change as the profession has steadily matured, is the repeated necessity to add more and more information to the nursing curriculum. In addition, expanding medical concepts about disease control and prevention have heightened the demand for nursing services and for nurses who are prepared to give these services in new and diverse fields.

Basic Courses

The first suggestions that the nurse has an important role to play in the treatment of alcoholism, and that it is necessary for information on this public health problem to be included in basic nursing courses, were received with some skepticism. This is not surprising if we remember that the concept of alcoholism as an illness—an illness that can respond favorably to treatment—is comparatively new. Vast numbers of the general public, and even a portion of the medical profession, have yet to be convinced of the validity of this concept.

To most nurses, as to the public at large, the alcoholic continued to seem a weak-willed, shiftless, somewhat immoral individual who could help himself if he would, but he would not. Furthermore, most nurses' contacts with alcoholic patients in hospitals did nothing to change preconceived notions. The obstreperous "drunk", throwing the emergency room into chaos and, incidentally, usually throwing the nurse into a panic, was a little hard to take. There were enough patients to care for who were "really sick." Why waste time on this "character" who had brought it all on himself? The bizarre behavior of the alcoholic—unless it is understood—leaves even the most compassionate nurse none too sympathetic.

Stigma

This is not a new or unique phenomenon. We have only to remember former attitudes toward contagious diseases and the treatment of patients with leprosy, mental illness, venereal disease, tuberculosis—all these were stigmatized conditions. But enlightenment gradually came and with it improved care, treatment and prevention studies, and reduced incidence of these conditions. What we do not know or understand we often fear, and fear leads us to shun or ignore a subject. Until quite recently this has been nurses' reaction to the problem of alcoholism.

When the nurse first found herself working with the alcoholic as a patient, she had no understanding of the specific nature of his condition. Hers was largely a trial and error method as she strove to learn how best to contribute to the care of these somewhat baffling, always elusive, and sometimes exasperating patients. Indeed, the medical profession, itself,

had no uniform idea on how this problem could be tackled. With some delineation of the problem and a keener focus on the kind of treatment needed, the nurse's specific role began slowly and gradually to emerge.

Experience has shown that not every nurse is able to work successfully with alcoholic patients. It has been said that alcoholic patients are challenging, elusive, and frightening. Therefore, the nurse who is planning to become a member of the team working with these patients must investigate honestly her motives for entering this type of service. She must ask herself, "Do I as an individual sincerely accept alcoholism as a disease?" If the answer is no, or if she has reservations or doubts on the subject, she had better not enter this special field. She will have small success in endeavoring to interpret to patients, their families, or the community something in which she, herself, does not sincerely believe. But the nurse who is fully convinced that alcoholism is an illness can accomplish a great deal in this field.

Other Characteristics

What other characteristics should a nurse have to ensure her making a real and satisfying contribution to alcoholic patients' improvement? She must be fully cognizant of the fact that alcoholics are individuals who have emotional problems and who may exhibit bizarre behavior patterns that require infinite patience and understanding on the part of those who care for them. And she must be emotionally and mentally mature herself. By and large, young nurses with limited experience find it harder to work with alcoholics than older, more experienced nurses do.

The nurse who works with alcoholic patients must strive to avoid exploiting the patient to serve her own emotional needs. There is no place in the care of these patients for the feelings of omnipotence or the domineering attitudes that some workers develop. Individuals with unsolved emotional problems of their own often tend to drift into fields of service where they deal with personality disturbances of one sort or another. This is seen so frequently in those working among alcoholics that the cereful screening and selection of staff is of utmost importance if these patients are to be treated properly.

Sometimes Childish

Many alcoholics are passive, dependent individuals. They know they are adults but they still have their childish longings to be taken care of. Some therapists believe that it is not wise to respond to them on the childish level and that, instead we should try to reach that part of the patient which is grown up. This is not always a simple or easy thing to do. Skill and experience are needed, in addition to understanding, and a sound knowledge of the dynamics of the normal as well as of the addictive personality.

Not only must the nurse accept alcoholism as an illness but also, she must have a thorough knowledge of the *kind* of illness it is. With the rapid advance of medical science, all members of the health team have become accustomed to expecting patients to get well and to do so rather quickly.

Unfortunately, this is not the case in alcoholism. To date there are no specifics, no wonder drugs, no magical techniques which will effect a certain cure. The nurse who is unfamiliar with this and other recalcitrant illnesses, and who is accustomed to seeing the majority of her patients recover rapidly, is

bound to find the long, slow progress —perhaps interrupted with many relapses—of the alcoholic's effort to regain his health a discouraging and frustrating process. Nurses who have worked in the field of mental health, tuberculosis, and other chronic, long-term illnesses may be b e t t e r equipped to cope with the alcoholic.

Mistaken Cure

Another pitfall for the uninitiated nurse, unaware of the dynamics of alcohol addiction, lies in the assumption that the patient is well because he makes such vast physical improvement in the early phase of treatment. A patient will enter a hospital in a truly deplorable condition. He has been drinking for weeks, he is malnourished, dehydrated, and perhaps he is suffering from an acute vitamin deficiency. His appearance may be slovenly or even filthy. He may be severely intoxicated, in an acute state of the jitters, perhaps in delirium tremens, or even in coma. Obviously, he is a very sick patient. Expert medical, nursing, and nutritional care is administered. Usually, within two weeks, notable improvement is evident. The patient looks "cured," and physically he well may be—this is one of the many paradoxes of the illness. Psychotherapy has probably been started in the hospital, and when the patient is discharged to an out-patient clinic for follow-up therapy, he seems to be on the road to good health. But in a few weeks this patient may return to the hospital in a worse condition than on his previous admission. When this happens, it can be most disturbing to the nurse who thinks he was "cured."

The nurse who works in the field of alcoholism needs to think of and plan for "improvement" rather than cure. If, over a period of years, Mr. Jones has never managed to maintain sobriety for more than a few days or weeks at a time, and he is enabled by treatment, hospitalization, and follow-up care to remain sober for six months, he has improved, even though he may slip at the end of that period. He has made a gain, not only for himself, but also for his family, his friends, and his community.

The nurse must be able to see this, and if he slips, she must accept it as matter-of-factly and unemotionally as she would the relapse of a patient with tuberculosis or diabetes. When those patients return with exacerbations of their symptoms, the nurse does not consider them "hopeless" or unworthly of her best efforts to help them again on the road to recovery, and so it must be with the alcoholic patient.

Team Approach

The therapeutic "team" approach has resulted in more improvement and more efficient care of the ill. Nowhere is the efficient use of the team more necessary than in working with the alcoholic patient. The nurse must be fully aware of the total plan for the patient; hence the needs for frequent staff conferences where patients' problems are discussed and where everyone who has any pertinent information which might help in understanding the total picture contributes his or her observations.

The nurse occupies a key position in these case conferences. While all other staff members have some contact with the patient during a day, the nursing staff has continuous contact with him throughout the 24-hour period. Over and over again we note that it is the nurse to whom the patient comes when he wants clarification on something that has come up when he was talking to the

doctor, or to the social workers, or the occupational therapist. Consequently, it is most important that the nurse be aware of the roles which other members of the team play.

By virtue of her close contact with the patient, she sees many facets of his personality that may never come out in the formal interview he has with other members of the staff. Her intelligent observation and recording of this information often provide helpful clues to the particular dynamics of a patient's behavior and the ways in which he can be helped toward recovery.

Nurses need to be kind and nonjudgmental in their care of alcoholics. These patients have strong feelings of guilt and they have been rejected by most people with whom they have come in contact since the onset of their illness. They react quickly to kindness and warmth, and it is interesting to see how well they accept the refusal of some of their demands if it is given in a kindly manner.

In the report of a study of 300 alcoholics, McClain Johnston pointed out that "the factor of a warm, consistent, understanding interpersonal relationship between the patients and staff members was most important in determining the response of the patients." While this, of course, holds true for all patients and all staff members in every field, it is particularly essential for the nurse who c a r e s for alcoholic patients.

If she is imbued with knowledge of mental-health principles and if she has a warm, kind, and accepting attitude, she can be a most important member of the team that is contributing to the total care of rehabilitation of the patient with a drinking problem.

Announcing

1958 Nurses' Institute on Alcoholism

TIME

Wednesday, April 30, 8:30 A.M.

PLACE

Auditorium of the Home Economics Building, Woman's College
Greensboro, N. C.

SPONSORED BY

The NCARP, N. C. League for Nursing, N. C. State Nurses' Association, N. C. State Board of Health, and the Greensboro Citizens Comm. on Alcoholism

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John A. Ewing, M. D., Ass't Professor of Psychiatry, UNC School of Medicine, and Coordinator of Alcoholism Treatment and Research, North Carolina Memorial Hospital.

Thomas T. Jones. M. D., Private Practitioner of Internal Medicine, Durham, and staff member of Duke and Watts Hospitals.

Richard C. Proctor, M. D., Psychiatrist at Bowman Gray Hospital, Winston -Salem.

Evangeline Soutsos, R. N., Ass't Professor of Psychiatric Nursing, University of North Carolina.

Member of Alcoholics Anonymous

'No fees will be charged nurses who attend. However, they will be expected to bear their own traveling expenses, board and room. Nurses from other states are invited to attend the Institute.

ALCOHOLISM AND NURSING

By Margaret Cork

- *An honest appraisal of a sometimes precarious relationship*

SINCE no other professional group has the same natural opportunity to be in contact with the alcoholic as the nurse, the question then arises as to why nurses have been unable to contribute significantly to the treatment or control of the illness alcoholism. The answer, I believe, lies in three factors: (1) the nature of this illness; (2) the resistance to sharing the treatment with other professions; (3) the fears, prejudices and other negative feelings often unrecognized or unconscious which affect nurses no less than the majority of our population.

In what way is alcoholism different from other illnesses? To begin with, there is no textbook definition of etiology or of treatment; there are no wonder drugs and no sure controls; there is no well-defined pain or diseased area, and the course of the disease shows about as many variations as there are patients. The alcoholic is sick socially, emotionally.

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and spiritually, long before there are any chronic physical conditions. Like the diabetic, he is up and around, except in the acute phases, often carrying on successfully at home and in business, but with the significant difference that for many years he refuses to recognize and to admit to ill-health. He must often lose family, friends and job before he accepts the need for treatment. In what other illness are there so many unpredictable relapses? In what other illness must the patient, in order to get well, give up the one anesthetic which can dull the pain of his suffering.

Do Nurses Understand?

We all know that medicine has come far in understanding and treating the whole person in relation to most diseases, but I wonder if something has not prevented the nurse from applying this concept to the treatment of alcoholism? How well do you really know the person who is afflicted? How readily can you accept him, not as you feel he should be but as he really is? Can you see behind the facade of drinking and pseudo-wellness to the fearful, defensive, compulsive person whose behavior is different, though often only in degree, from that of other sick people? How able are you to accept and understand emotionally, as well as intellectually, that the lying, the broken promises, the irresponsibility and the rationalization of the need to continue on the path to self-destruction, are just as symptomatic of the illness as the excessive consumption of alcohol? Have you, like many others, come to know a lot about alcoholism but experience difficulty in applying it to your efforts to help the alcoholic? Can you relate to him as though you really understood the limitations of his sick personality, or do you act as though all his problems would be solved if you could compel him, or persuade him to stay away from alcohol?

The second factor which would seem to be influencing the nurse's contribution to the problem, is the seeming inability of all service professions to work effectively together on a long-term basis toward a common goal. To be sure, doctors and nurses have worked together in a particular relationship since the beginning of professional nursing, but perhaps this very fact has made it more difficult for the nurse to share treatment with others whose field has not primarily been treatment of disease.

Working Together

From knowledge of the disease alcoholism and of the alcoholic personality, I feel that no one professional group alone can treat a sufficient number of alcoholics to make an appreciable inroad on the size of the problem today. Out of each individual profession's failures to help the alcoholic and from the experience of the shared approach of the clinic team, it is my belief that only as all those who are in contact with the alcoholic can see themselves as members of a community team will we begin to control this illness effectively. Just as the clinic team works together, each member bringing particular skills to the problem of rehabilitating an alcoholic, so can the nurse in the community share with clergy, lawyers, teachers, employers, recreation workers, personnel workers, psychologists, doctors, and social workers, the problem of treating the alcoholic and of carrying out a program of secondary prevention.

This means that there must come into being a greater professional maturity on the part of all service professions; there must be a new

awareness of individual roles and limitations; a giving up of some of the old competitiveness and rivalries, and a gaining of a new tolerance for the skills and quality of service offered by complementary professions; and last, but not least—it implies a freedom from the possessiveness we have all experienced and exemplified by the term "my patient."

In spite of our increased knowledge there are still many in the service professions who will react to the alcoholic with intolerance, impatience, and a moralizing or punitive attitude. The alcoholic, however, can be helped to handle this reality if he is prepared beforehand and given your support to face it.

An important aspect of this teamwork is a new awareness of the patient's right to share in any plans for his treatment. Too long have we shown our disrespect for him as a person by denying him the opportunity to decide when he will be referred and what information will be shared about him. Another "must" for working together is a sense of responsibility for interpretation. Unless all those who have an investment in a treatment program can begin to use every opportunity to give thoughtful interpretation to friends, colleagues and families of alcoholics, we will not succeed very quickly in changing public opinion, in building up new attitudes towards the illness, without which no effective control is likely to take place in the immediate future.

Know Thyself

So much for a way of working together. What of my third point, your own attitudes? Just as I have stressed the importance of knowing the person who is ill, so is it equally important to know oneself in relation to this illness. I refer here to the often unrecognized feelings and reactions to drunkenness, to excessive drinking, and to the great dependency of the alcoholic. Unless you recognize that you have feelings begin to understand them, and learn how to cope with them, your ability to help the alcoholic will be severely limited.

Some Prejudice Inherited

Most of you inherited or acquired a relative degree of conflict, prejudice, and misconception about the use of alcohol. There is little in your training that helps you to lose or work through this, but in order to work successfully with alcoholics a degree of tolerance, of objectivity, must be achieved about other people's use of alcohol and you must have found a comfortable solution to your own use of it. Unless you do, you will almost inevitably bring to your relationship a bias and variety of reactions and feelings to which the alcoholic will react in a negative way. You may consciously or unconsciously look down on him, moralize or punish; you may consider him stupid because he cannot drink as others do, or weak-willed because he cannot leave it alone. His drunkenness may cause you to react with disgust or fear, and thus you will reject him as surely as though you had turned your back on his appeal for help. Some nurses may be able to relate to the alcoholic when there is opportunity to really "nurse" him, but once he is up and on his feet the negative feelings and prejudices begin to operate and there is little sympathy for his continuing, often increased, state of suffering as he struggles again to face life as an adult with the handicap of emotional immaturity, and without his comforting self-medication.

Often the great dependency of

the alcoholic is a greater hurdle for those working with him than the excessive drinking bouts. We all know that healthy emotional growth comes from the quality of love received from infancy on. Many alcoholics suffered from an experience of too much or too little love in childhood, and so have been arrested in their emotional growth; others who were not so deprived regress as the disease progresses so that at the stage they come for treatment we see all of them as physically and intellectually mature but emotionally immature people, with a tremendous, though varying degree of need for infantile satisfactions.

Illness Brings Regression

You who have nursed in hospitals can perhaps best understand and accept the regression which we all experience in some degree when we become ill. Much harder to recognize and accept are the more subtle aspects of dependency, seen in the alcoholic's inability to accept responsibility, his tendency to give up easily, his denial of need for help, his belittling of dependency in others, his jealousy, his impulsiveness, his reaction to authority, his overtalkativeness, his demandingness. Like the child, the alcoholic has a confused sense of his own worth, his dominant emotions are destructive rather than constructive; he needs to project blame on to others; he has much sexual conflict; and last, but not least, he has constant difficulty in facing reality.

His great dependency needs may threaten your own adjustment and you will react to him, in accordance with your own needs, by overindulging him or by minimizing his needs. You may find it ego-satisfying to encourage his dependency or refuse him any, once he is over his drinking bout. Without understanding the dependency factor, your ability to help the alcoholic is limited.

What, then, are some of the specifics of treatment? In most long-term illnesses, be they physical and/or emotional, the relationship between the patient and the helping person is of great importance. In the treatment of alcoholism it is vital, and I would like to spend a few moments looking at the quality of the relationship which will most likely help the alcoholic. Above all he needs to see and to feel some of the steady, consistent, warm, loving qualities that the young child receives from its mother, and without which it cannot grow emotionally. While in no sense should we treat the alcoholic as a child, he must, like the child, be understood and accepted as an emotionally immature person, with an expectation for growth related to and limited by where he is emotionally and what there is to build on.

Such a relationship with the irresponsible, often defiant person who continually needs to test you, is far from easy: It demands a high degree of integrity and inner security on the part of the nurse. It calls for infinite patience and a constant awareness of one's own feelings, so that they will not get in the way of what you are trying to do. It means you must know and feel his suffering, his fears, his loneliness, his discouragement, and yet not overidentify with these or be impatient with him because he does not do the obvious or so-called normal things to get rid of these feelings. This does not imply that at times you will not have strong feelings or that you cannot show concern, disappointment and even anger, so long as these are not directed against the alcoholic nor used primarily as an outlet for your own needs.

Important to your relationship with an alcoholic is an awareness that he is not only having to learn to take on new ways of coping with life, but he is having to give up many relatively satisfying or protective attitudes and ways of behaving, not least of which is giving up his only means of escape from pain.

Obviously the intensity of your relationship will depend on whether or not you are playing a major role in his therapy, and this in turn is colored by the demands of the total job, but the basic qualities of the helpful relationship are essentially the same. While it may not be possible for a nurse in a particular setting to build up an intensive treatment relationship with the alcoholic, time must be found to establish sufficient positive relationship to refer him to the appropriate person on your "community team"; to help him directly or indirectly to face some of his other problems until he is ready to face his alcoholism. This does not mean that the alcoholism can be ignored or that it does not eventually have to be faced one way or another, but he may need to test you or learn to trust you before he can bring his problem out into the open. Often those helping an alcoholic are so anxious that they are too direct; others never really free him to discuss the subject naturally.

Prevention

The nurse, like others working with alcoholics, should be concerned with and involved in primary prevention. One specific role of the nurse in prevention is that of enabling the wife and family of an alcoholic to find and use an appropriate source of help, while in general her role becomes a matter of doing what she can to strengthen the way of life for all families in her community. This may be done directly or indirectly through counselling parents and enabling them to learn how to become emotionally strong enough to give their children the kind of love which will help them to grow.

Another aspect of prevention lies in the area of education. In your informal day by day interpretation to alcoholics, to families, or other members of the community, it is important, as it is in any formal program of education, that you present the illness as one form of mental ill health, one symptom of an individual's inability to face the realities of life. The more we isolate this illness the more we tend to increase the alcoholic's sense of isolation from his fellow man and increase the community's sense of the alcoholic being a social outcast, of alcoholism being something that could not happen to them.

The nurse's role will vary with the setting in which she works, but all her efforts to rehabilitate the alcoholic should contain elements of treatment, direct or indirect, of education, and of prevention. While the intensity of her individual contact will often depend on the demands of her total job, it will more significantly depend on the quality of the relationship she is able to establish with an alcoholic or his family. Although individual nurses have in the past intuitively worked successfully with the alchoholic, it would seem as though the nursing profession as a whole, to date, has not brought the best of its proven skills and abilities to understanding and coping with the problems of alcoholism. It is my conviction that without the intensive help of the nursing profession there will be no widespread success in the treatment and control of this illness which is seriously affecting the lives of so many of our fellow citizens.

THE majority of nurses probably will be concerned with the direct care of the alcoholic patient. In fact, a nurse may contribute in a large measure to his recovery without ever seeing him, for it is often necessary to begin with the family rather than with the patient himself.

The nurse's own attitude, feeling, and reaction to alcoholism as a behavior disorder will definitely influence her effectiveness in establishing a satisfactory relationship and rapport with the family, and they may eventually help her to lead the patient to treatment.

By the time the alcoholic's family is willing to discuss the problem with an outsider, for example the nurse, most members of the family have sustained over a long period of time so many traumatic experiences, due to the alcoholic's behavior, that they are as fully in need of therapy—if of a different type—as the alcoholic. In some instances the task of the nurse would be to refer the family to a suitable treatment resource in the community. Here the importance of the nurse's being aware of the facilities in her community is obvious. The family of the alcoholic, in common with many others, often has the mistaken notion that social agencies exist only for extremely underprivileged members of the community. Having long suffered from the stigma of an alcoholic in its

There are more people involved in the successful treatment of alcoholism than just the alcoholic alone. Nurses are now beginning to realize the importance of the family — many times they need help too.

The Alcoholic, His Family and His Nurse

BY GRACE M. GOLDER

Condensed with permission from "Nursing Outlook", Oct. 1955

midst, the family may well feel that the public clinic is the final ignominy.

Here the role of the nurse as an educator becomes apparent. If she is able to discuss the nature of alcoholism calmly, patiently, objectively, and quite matter-of-factly, she can do much to relieve the family's anxieties. She may be the first one to make the family aware of the nature of the problem. The family's despair that anything constructive can be done is often the biggest obstacle to overcome. Families often feel that they have exhausted every resource in an effort to stop the alcoholic from drinking. They have preached and scolded and argued. They have tried pleading, force, and threats.

In almost all cases the alcoholic's family is overwhelmed by guilt feelings, feeling that in some way it may be responsible for his condition. Parents often ask, "What did I do wrong, where did I fail that he should turn out this way?" The alcoholic, himself, in attempting to overcome his own guilt, often blames his parents or someone else in the family. And for varying periods of time—the alibi stage—they have had to bear the brunt of his accusation that they contributed to his drinking.

Then, too, the hostility and resentment engendered by the mental and

often physical abuse, which members of the family have suffered as the result of the alcoholic's behavior, frequently contribute to their guilt feelings. This is often true in the children of alcoholics. Taught from the earliest childhood to love and honor their parents, convinced that this is the only socially acceptable behavior, feelings of disgust, revulsion, and even hatred toward the alcoholic parent can set up severe conflicts in the child.

Case History

For example, John had been coping with his widowed mother's alcoholism for ten years. On innumerable occasions he had to make the rounds of the taverns to bring her home. Now a student in college, he had no conception that there was any help available for his mother until he heard the Yale Plan Clinic referred to in a talk given by a nurse. After several visits to the clinic he was able to verbalize his obsession with the idea that one day he might kill his mother to save her from suffering from a worse fate. The guilt and remorse that this boy felt because of these feelings were very severe. He was seen frequently while his mother was receiving treatment at the clinic. Treatment was successful for both mother and son. This illustrates the importance of the approach to the family rather than just treatment of the alcoholic patient.

As the attitudes of the family member toward the alcoholic and his problem change, the effect is bound to permeate to the patient himself. As their attitude becomes more accepting and understanding, he will sense a change in their reaction to his drinking and thus be more amenable to seeking help. Often the alcoholic's husband or wife is not the person of choice for this task. For example, a visiting nurse was able to make the daughter of an alcoholic, rather than his wife, see that a change in the family's attitude and feelings toward her father's drinking might be needed before he would be willing to accept help. The nurse's approach was right; had she not understood the problem so well, many more years might have elapsed before the way was cleared for this man to get well.

The nurse need not be afraid to sympathize with the alcoholic's family. Most such families have had a hard time. The nurse's sympathetic understanding will do much to help them and, through them, help the alcoholic.

Sometimes persons living in communities where there is a rather wide variety of treatment facilities and allied resources available tend to forget that in many sections of the country such resources or facilities are lacking. If little or nothing has been done in a community to provide facilities for helping the problem drinker, a nurse might do well to secure the interest of an understanding and friendly doctor who would be willing to render emergency assistance and to work in cooperation with her.

What can be done if emergency care for an acutely intoxicated patient is needed? The value of a 30-day commitment to a state mental hospital for the care of the alcoholic who has reached the stage at which he constitutes a menance not only to himself but to his family and the community should not be overlooked. The nurse needs to be particularly skillful in pointing out how this commitment may be used constructively There is still much revulsion and even horror at the idea of committing a loved one to an institution of this sort. The despair-

ing family may well regard this as the end. The nurse can point out that rather than an end, this, in fact, may be a beginning to a solution of the problem. The patient's drinking will be interrupted, he will have a chance to sober up, and with the cooperation of the family, he can be made to see that he really does need help. The family must make the patient aware of the fact that his commitment is not a punishment, but rather something that had to be done in order to protect the family from his irresponsible behavior and also to protect him from himself. The very knowledge that his family was forced to act in this way may motivate him to seek help.

Threat of Jail

Even more threatening to the family and to the alcoholic is a jail sentence. However, if the state mental institution is far removed from the community, jail may be the only alternative in an emergency. Again, cooperation from the family in explaining why his arrest was necessary may be the beginning of treatment. Many jails already have some type of program for helping the problem drinker.

Facilities of this kind can be used to provide emergency care in an acute medical condition, or to protect the patient and his family, or to interrupt a drinking bout when no other facilities are available. But what can the nurse do when the patient's needs, although not so acute, are nonetheless imperative? If there is a general hospital in the community it can be used to sober up patients and to give them emergency medical care. Formerly general hospitals did not want to admit alcoholics, fearing that their effect on hospital routine would be too disruptive. But many hospitals have now found that they can set aside a few beds for these patients.

The indifferent "sobering-up" routine in the emergency room—which is apparently undertaken only because it is inescapable—is the limit of many hospitals' interest in alcohol adiction. The patient is given symptomatic treatment to get him on his feet and out of the hospital. All too often he is turned over to the police or left to his own devices without any constructive suggestions or help from the staff.

To say that other patients are more deserving of care or that the alcoholic just does not fit into the service is no excuse. With some education of the hospital staff, these patients can be cared for without disrupting hospital routine. Furthermore, segregation of these patients in a special unit is no longer considered necessary.

The care of alcoholics can also be incorporated in clinical teaching of staff personnel and nursing students. This educational opportunity in itself will provide for an increasing number of hospital service personnel the opportunity to learn more about alcoholism and the multidisciplinary approach that is needed to treat and rehabilitate alcoholics.

Shelters, such as those that are maintained by the Salvation Army and various church and mission groups, must not be overlooked as other resources in the community that the nurse can use particularly when she is working with the alcoholic rather than his family.

Shelter Will Help

Sometimes an alcoholic may be helped more by a shelter than by any other agency. Some patients who simply cannot discuss their problems with a social worker, nurse, or doctor are able, in the protective aura of the shelter, to talk out their problems with some kindly and

sympathetic staff member. The very use of the word "shelter" rather aptly describes what the lonely, isolated, and sick alcoholic is looking for.

Valuable Resources

Alcoholics Anonymous is another invaluable resource. While all alcoholics cannot accept the philosophy of AA, every effort should be made at least to acquaint the alcoholic patient with an AA group. These groups are to be found in practically all communities.

Religious facilities must not be overlooked. In some cases the patient's only effective therapy is to return to his childhood faith. A great sense of guilt at having violated all the innate training in religious attitudes has built up in him the conviction that not only is he cast off from the communion of his fellow men, but, far worse, he has been abandoned by God.

If he can be convinced that God will accept him, he may begin to feel that perhaps people can again accept him. The nurse who is anxious to help alcoholics should establish rapport with the clergymen of various faiths in her community; and she will have an opportunity to do her bit toward educating them in how they can help these people.

No single group of nurses is responsible for interpreting the problem of alcoholism to the community. The public health nurse, who is accustomed to working in cooperation with the patient, his doctor, and any community agency that enters into the patient's care, is in an excellent position to steer the family of the alcoholic to treatment resources, provided she is aware of them.

Industrial nurses are becoming increasingly aware that the use of community resources can heighten the effectiveness of their work. As industry is beginning to cope with the problem of alcoholism, industrial nurses are being impressed with the need to know more about it and to learn what they can do about it.

The nurse who is working in a hospital may have fewer opportunities to utilize community resources. However, with a knowledge of the problem she can find the opportunity many times to help an alcoholic patient or his family.

The nurse-educator is in a position to integrate in the curriculum the study of existing resourses. At the Yale University School of Nursing, for example, a lecture on the tuberculous alcoholic is included in the students' course in tuberculosis nursing.

In brief, the nurse who wishes to help the alcoholic and his family, and to interpret the problem of alcoholism in the community, must be fully cognizant of any and all resources that she can utilize, in addition to educating herself in the nature of the illness.

TO ALL NURSES

WE are beginning to realize that adequate treatment not only of the psychotic patient, but of all patients, requires a double approach and a double understanding. It requires a profound knowledge of the physics and chemistry of living processes, with their repercussions in bodily and emotional behavior, and also a deep understanding of the emotions or feelings of people as they influence both bodily and chemical processes, intellectual functions and one's total behavior.

From EMOTIONAL HYGIENE
by Camilla M. Anderson, M.D.

12 "MUSTS" FOR NURSES

in the treatment of alcoholism

1. Have a thorough knowledge of the nature of the illness of alcoholism.

2. Honestly evaluate your motives for entering the field of alcoholism treatment.

3. Be mentally and emotionally mature.

4. Have patience with and an understanding of the alcoholic as a sick person.

5. Be accepting, sympathetic and non-judgmental in caring for the alcoholic.

6. Try to reach the adult level of the alcoholic patient's personality, not the childish, dependent level.

7. Be careful not to consider the seemingly well patient "cured."

8. Think in terms of improvement rather than cure.

9. Be careful not to exploit the alcoholic in seeking satisfaction for your own emotional needs.

10. Accept a patient's relapse or "slip" unemotionally.

11. Be aware of and cooperative with the "team approach" to treatment.

12. Be aware of available treatment facilities for alcoholics and adept at convincing the patient's family that help is needed.

The Legend of

A SHORT STORY

EVERYBODY from miles around came to Jeff Caldwell's funeral. It was the biggest day Richfield had seen in many a year and it was also the saddest. Their town drunk was dead and people wondered, and when they couldn't explain, they built up a legend about Jeff, about what a fine man he was, and how it wasn't his fault he drank too much, and what a noble thing he had done to save them all from evil. They said all this because they didn't understand what Jeff really was and they had to say something about him.

Jeff didn't like being the town drunk. He didn't like drinking and he didn't like what made him do his drinking, but he had no choice. That is, Jeff always said he had no choice.

Everything had always been against Jeff, so he said. When he was born, his mother died. Almost the minute he let loose with a wail, she died. It was like she had known what a problem he would be and she just wasn't up to it. Jeff never forgave his mother for leaving him, even when he was a grown man, he never forgave.

Jeff's pa was a drunk, too, although not quite as bad as Jeff himself grew to be. When Jeff was little, his pa would often leave him alone for days at a time, while he roamed the woods around Richfield, hunting, fishing, drinking. Sometimes he'd be gone a week or two and during those times, Jeff more or less had to raise himself and maybe that accounted for why he was like he was. He stayed too much to himself.

Jeff was smart as a boy. He loved guns and had great ambititons of being a policeman and getting married and "making somebody of himself." He didn't become a policeman, though, because by the time he was old enough he'd lost interest. In fact it seemed the older Jeff got, the lazier he got—sort of as if he thought it wasn't any use. But he did get married—to Vernie Jones.

Vernie was called "wild", loved dancing, parties, putting on lipstick and high-heeled shoes. But Jeff thought her wildness was beautiful and he loved her. Jeff thought he could calm Vernie, so he got a job as a mechanic at Field's Service Station, rented a nice apartment, got some second-hand furniture and got ready to settle down. The only fly in the ointment was that Vernie wasn't ready to settle down. She wanted parties and when she couldn't find one, she'd make her own and that's when the trouble began.

A dream took hold of this

Jeff Caldwell

By CLAIRE CHENEY

Vernie held her parties every night, right in the apartment. Only two people came to those parties—Vernie and Jeff. They'd eat supper right after Jeff got off from work and then with a giggle, Vernie would bring out the bottle and set it on the kitchen table along with the dirty dishes. They'd sit there, just the two of them, talking, listening to music from their Sears and Roebuck radio and they'd watch the amber liquid within the bottle get smaller and smaller.

At first Jeff didn't approve of Vernie's "parties", but then he'd never tasted alcohol, except once when he was 12 and had a sip of wine from his pa's glass. But Jeff learned —oh, how he learned the joys that the amber liquid could bring him. He became a new person sitting right there at that kitchen table. He was first the richest man in the world, then a United State Senator, then a famous policeman. But his favorite dream was the one about the bank robbers.

The Bank of Richfield had been robbed four times within those past three years and people began to think it was jinxed it'd been robbed so often. In Jeff's dream, the robbers would come again and he would capture them, single-handed he would capture that band of theives who had come to rob the people—his people—of their money. It was a wonderful dream and he imagined it all sorts of ways. First he'd shoot them, then carry them to the police one at the time, while everybody waved and shouted his glory. Next, he wouldn't shoot them; he'd just line them up against the wall and hold them there all by himself, until help came, and then he'd take the stolen money and with a flourish, present it to the bank president.

Either way Jeff imagined his dream, he was always the town's adored and beloved hero for saving them all from ruin. Everything Jeff had ever desired was in that dream and he could have it all, sitting right there at that kitchen table, with Vernie.

But Vernie got bored. She got tired of the months of listening to Jeff's drunken ramblings, tired of putting him to bed every night, tired of no money. She wanted gaiety and laughter. So one night when Jeff came home from his job, he found a note and as he read it, he felt the same way he did when his pa used to tell him of his ma's death. He felt forsaken.

A change came over Jeff that night. Everyone had left him now;

man, a dream to be "somebody"

his ma, his pa, and now Vernie, and there was nothing left for him to do but sit at the kitchen table every night and drink himself to sleep.

So the bottle became mother, father and wife to Jeff and Jeff's constant fear was that it, too, might leave him. So he made all sorts of precautions. With a week's pay, he'd buy just enought food to live on and the rest went to liquor. Then he'd take the bottles full of that life substance and hide them—sometimes he'd hide them so well even he couldn't remember where they were. In the clothes hamper, the furnace, the shack he called a garage, in the oven, behind furniture, even in the soft dirt. Jeff surrounded himself with his security. Those bottles were more than just a few drinks, they were his family and he loved and hated them no more than if they had been flesh and blood. But even that was not enough for Jeff.

He'd dream his dream. In the reverie of sweet drunkenness, he'd envision that glorious event. Children would ask for his autograph, the town would make him a gift of money for his bravery and Vernie would come back home—all for capturing a few bank robbers. Jeff knew it was childish—this dream—but it had become so real to him that he even bought a gun and at night between drinks he'd take it out of its case and rub his hands over and over it, leaning his head back against the chair with his eyes closed and a smile on his lips, thinking of the day when he'd use it. Often he'd go to sleep just like that, rubbing that gun, and he'd not wake up until morning and it was time to go back to fixing carburetors, cleaning spark plugs, and grinding valves at the shop.

Of course, no one in the town knew of Jeff's dream. To them, he was just their town drunk, something to be tolerated, to be amused at. Every town's got a drunk, they said, and we got Jeff. They were sorry about his ma and about Vernie, but it really was no concern of theirs, they said. We got enough trouble looking after ourselves without bothering about some old sot, they said.

A few knew about Jeff's troubles and knew about his drinking and they felt sorry Sometimes the boys hanging around the street corner would give him a quarter or two when they'd see him coming home from work, when he looked especially bad, but even they said, "Well, he's got a job, ain't he? If he ain't got nothing else, he sure got a talent for working on automobiles."

But Jeff soon lost his job. "Not enough work coming in," said the Boss, but Jeff knew better. He knew he hadn't been doing a good job. Cars weren't fascinating to him any longer. His mind and body seemed lulled by some inexplicable thing. He wasn't interested in bolts and grease and gasoline tanks any longer. A desire had taken hold of Jeff's soul and he was helpless to it.

Jeff wasn't sorry when he was told he was fired. In fact, being fired seemed the natural course of events to him. His ma, his pa, Vernie, and now his job. But he had something now to take their place—his bottle and his dream. Of course, without a job, Jeff would have no money and this really posed a problem, for without money Jeff would have no bottle, and without the bottle, there would be no dream and for Jeff, no reason for existence. But this was of no great concern to Jeff, for he had a little money stashed away and besides, he had all those bottles.

It took a long time for Jeff to decide what to do. His mind wasn't

as quick as it used to be. It took longer for him to think things out and then sometimes he'd get confused as to who he *really* was and then he'd think he was someone else —someone perhaps of noble birth, like the story he'd read in childhood about the prince and the pauper—someone meant for great things.

Then other times, the pain of knowing he was Jeff Cadwell and who he was would be so great that he'd fall into an alcoholic daze where the only voices he could hear were those of his mother and his sweet Vernie. But all the time, he was planning—planning his dream. Fulfillment of that one desire had Jeff possessed and his mind became alert in anticipation of that morning after the battle when the boys on the corner would bow to him in admiration, the ladies would call him "Mr. Caldwell" instead of "Jeff" and the men would slap him on the back and call him"buddy". And they all would love him because he had saved them from evil.

And so Jeff arrived at a plan and took up station in front of the Bank to wait. The spot beneath the tremendous elm which bordered the sidewalk became his office and Jeff sat there day by day in wait of the bandits who would come to help him fulfill his dream. No one disturbed him there. It was as if the town knew something was going to happen and Jeff knew it too.

And as he sat there and watched the people walking by, heard them talking and laughing, Jeff became full of a sense of importance. He was the town's protector, only *he* had the vision and courage to sit in wait of the evil which would try to overtake them all. He was the appointed.

Inside his coat, Jeff kept the gun and a small scarred flask which he had found on the street and every now and again when he felt no one was looking, he'd bend his head down into the inside of the coat and taste the warmth of the alcohol, feel it burn his lips.

Jeff sat in front of the bank every day and waited. Until one Saturday, right at 12 noon, a black car drove up to the bank and three strangers got out, save for the man behind the driving wheel who looked anxiously to his left and then to his right. The strangers were well-dressed—too well-dressed for Richfield and it was this fact that made Jeff look at them so hard and so steadily. They each carried a shiny black briefcase in their left hand with their right hand stuffed in their coat pocket. Jeff saw this and he knew it was they and what he had to do.

The strangers looked at the man who stared at them and then shrugged their heads and made a movement with their mouths to indicate their disgust for this dirty, drunken man. Maybe it was this that made Jeff do what he did or maybe it was because he had rehearsed it in his mind so much. For Jeff jumped those men and knocked them down to the ground and when they started to pull out their guns, Jeff already had his gun out and he shot them one at a time. And when he thought they were dead, he threw down his gun and started to weep at what he had done and tears so filled his eyes that he didn't see one of them reach up from the ground and aim his gun right at Jeff's stomach. He didn't see the bullet fly through the air and hit that vulnerable place in his body.

The boys on the street corner came after it was all over and carried Jeff away. The strangers, they found

out, had sure enough come to Richfield to rob the bank, that ill-fated bank and they would have done it if it hadn't been for the dirty, drunken old man who had a dream that someday he'd save his town from evil.

The funeral was magnificent, just as Jeff had imagined. There must have been two hundred people there and they cried over their hero and commented on how beautiful the flowers were. They spoke of how smart Jeff had been as a boy, of how his family had not treated him right, of that hussy Vernie who had left him and how they had known all along that Jeff was more than just a drunk.

Jeff became a legend to Richfield and his name was echoed softly and with awe throughout the town, in the churches and in the front parlors of the beautiful homes that Jeff so often admired. They spoke of their hero reverently, and of his drinking, they said, "Well, he took a nip now and again, but not enough to speak of." Of his laziness, they said, "He just never found the right work, poor man."

But there was one question which none could answer. Why had Jeff been sitting there in front of the bank day after day and why did he have a gun? Many said Jeff must have known all along what was to happen, but then others said don't be silly, how could he have known?

But then, they don't know about dreams and what they can do. They didn't know that more than anything else in his world, Jeff wanted to be "somebody" and that when you're possessed with a dream like Jeff was, you can do things and things come to you that maybe don't quite seem natural, like wishing so hard that something would happen that just the wishing makes it true.

The town of Richfield never really understood what happened that day, but then Jeff didn't mean for them to understand. And even today when people walk past that Richfield Bank around 12 noon on a Saturday, they get the idea that somebody's staring at them, but when they turn around, nobody's there. But still they can feel somebody standing there staring at them and grinning ever so slightly.

How To Recognize An Alcoholic

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and in his personal life with the disintegration of his health.

Any one of these sets of problems would be enough to cause an average person to limit or stop his use of alcoholic beverages. For him the solution is logical and not too difficult. An alcoholic, however, may see with equal clarity that in order to straighten out his life he must cut down or cut out his drinking, but he will fail to do so because he cannot do it without help. He will keep on drinking even though he knows that his drinking causes a continuing and deepening problem.

Cardinal Signs

We have suggested here some of the cardinal signs of alcoholism—the essential characteristics of the ailment, several give-away symptoms in the realm of drinking behavior, certain manifestations that may be observed by someone very close to the alcoholic, and evidence related to the problems caused by continued ex-

cessive drinking.

These signs are useful in helping one to decide whether a person under observation is or is not an alcoholic. A decision in this matter is important, for upon it depends the kind of help that is offered to the one whose drinking is causing the trouble.

Should Understand

Relatives and good friends of a person who is suspected on good grounds of being an alcoholic should be advised of the fact in order that they may not be unfair in judging him or unwise in dealing with him. They should understand that alcoholism is an ailment, and that an alcoholic should be treated with full regard for his illness.

It should be recognized that a layman's diagnosis of alcoholism has its dangers and limitations. Wherever possible, the counsel of experts should be sought.

Program Pointers

(Continued from page 4)

might be considered better equipped to make these decisions.

Other evidences of the changing attitude toward alcoholism are apparent in the professional educators themselves. Educators at all levels are now showing greater interest in good, objective alcohol and alcoholism education and are seeking reliable and helpful information and material for use in the classroom. Pupils who have been exposed to alcohol education are accepting the fact with maturity and seriousness. School age boys and girls are interested in learning about alcohol and welcome an honest attempt on the part of the teacher to give them accurate, objective facts.

In recognition of the changing attitudes and because we want to further the amount of teaching about alcohol in the North Carolina public schools, the NCARP is providing a limited number of scholarships to Yale Summer School of Alcohol Studies. The scholarships are open to certain groups of professional people, including professional educators at the supervisory level.

Special Resource

As a special resource for the classroom teacher, the NCARP sponsors each year summer studies on alcohol in some of the N. C. colleges. The summer school courses are particularly designed to help meet the needs of the classroom teacher and provide an objective and constructive approach to the problems of alcohol which will be applicable in their teaching.

1958 Summer Studies

This year the summer studies will be held at the following colleges: June 3-13, East Carolina College, Greenville. June 10-20, North Carolina College, Durham. June 23-July 4, Woman's College, Greensboro, June 23-July 5, A & T College, Greensboro.

Applications for admission and other correspondence concerning the summer schools should be addressed to the Registrar at each of the colleges.

We hope that our teachers will continue to respond to this service as they have in the years past and that we can continue to see evidences of improvements as we have since these courses were originated.

Books of Interest

NO HIDING PLACE

By Beth Day

Henry Holt & Co., Inc.
New York
273 pp. $3.95

THIS is a book which has received a great deal of publicity lately, both in newspapers and on television (the author recently appeared on "This Is Your Life"). It tells the story of Vincent Tracey, a one-time "boy genius of Madison Avenue" who became an alcoholic and wound up a Bowery Bum, losing his job, his friends, his fiancee and his self-respect.

At age 30, Tracey was declared the boy wonder of Fifth Avenue, as assistant to the president of one of the large and well-established department stores. At 35, he was declared a bum, making the rounds of institutions and hospitals, selling the clothes off his back for a drink, and trying suicide on three different occasions.

Today at 46, Vincent Tracey is the owner of Tracey Farms, a home for problem drinkers in upstate New York, where he teaches that triumph over alcoholism is a matter of self-discipline, of will power. Alcoholism, he says, is not a disease. "With me, it was a softening of my will and loss of guts."

Another theory Tracey teaches at his farm is that "alcoholism is a mental weakness . . . man creates the habit, supports the habit and eliminates the habit."

In this book, the story of his life, Tracey says that he has had great success with alcoholics who come to him for help. He helps them re-gain their self-respect, doesn't "coddle them by telling them they're sick," teaches them to accept life as they find it. He doesn't believe that AA, psychotherapy or hospitalization is the answer to alcoholism.

His theories are all very well and good, but in saying that alcoholism is *not* an illness, Mr. Tracey has forgotten one thing. Is not an inability to accept life (which Mr. Tracey admits is part of an alcoholic's trouble) a sign of an emotional disorder? If one cannot accept himself and his surroundings without the anesthesia of alcohol, then is not the core of the problem centered around the cause of the excessive drinking, that is, the emotional illness? Some alcoholics might be able to say, "I'll never again. It's all a matter of my will" and never again touch a drop, but for most, the solution lies deeper.

Another point which Tracey makes in relating the story of his recovery is the help he found in the discovery of *his* God. In effect, he tells that he turned his life over to God. Is this not one of AA's twelve steps . . . "to make a decision to turn our will and our lives over to the care of God as we understand Him."?

Before Mr. Tracey shouts his theory that alcoholism is a moral weakness to the skies, it might be well for him to examine closely just what a moral weakness is. He might find that his idea of a moral character defect is what professionals in the field of alcoholism call a *symptom of an emotional illness.—Claire Cheney*

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

STATE LIBRARY OF NORTH CAROLINA
3 3091 00822 3158

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